The Journal of the American Medical Association

VOL. XXIV. CHICAGO, JUNE 29, 1895. No. 26.

ADDRESS.

ADDRESS ON THE FOUNDING OF THE ILLINOIS HOSPITAL.

Delivered in Central Music Hall, June 12, 1895.

BY SETH SCOTT BISHOP, M.D.

CHICAGO.

The purpose of this pleasant meeting, held under the auspices of the gallant Columbian Knights, is not a mercenary but a merciful one. There are some good people who entertain the idea that doctors are like ministers—in one respect—that they are always asking and receiving. These are the excellent citizens who pay their bills. There is another large class who realize that doctors are persistent askers but poor getters. These are the beneficiaries of our good-natured Esculapians, but they would have their doctors work for nothing, board themselves and go to the Chicago River to drink. Medical men have learned, perforce, that it is more blessed to give than to receive, and we are not here to ask more than we are willing to give.

Every prosperous citizen owes a certain obligation to the community to which he is indebted for his prosperity. There may be poetry but there is no romance or fiction in my remark that doctors work for nothing. I speak from experience. During the past fifteen years I have served on the staffs of more than half a dozen of our charity hospitals and dispensaries, and, like all the other attending physicians, have never been paid a dollar by any one of them. But once in a while the sweet, strange melody of "thank you" tickles the auditory nerve. I am often asked: "Why do you work without pay?" I will tell you our secrets. First of all, we love our work. No other citizen endures more trying ordeals, or subjects himself to greater personal sacrifices for the pure love of his labor than the conscientious charity physician. By this means, also, he becomes perfected in his art and known for his skill. There is a satisfaction, a fascination about the medical and surgical treatment of large numbers of our fellow beings that words can not portray. Who would not be a valiant knight, the general of an army, or even a colonel—if he could? Who would not risk his ease and comfort to save a man or helpless horse from death?

Do we need another hospital? If you have tried to secure the admission of poor patients to our hospitals since the World's Fair you will answer this question in the affirmative. It is difficult for influential physicians to open the hospital doors to their own patients, and next to impossible for you to find an empty cot for your sick or injured friend. The city has outgrown its hospital facilities. The county institution is over-full. There ought to be a district hospital in every populous ward. Much suffering and many lives could thus be saved. The chances of the sick, and of the wounded who are subject to shock and bleeding, are imperiled by long jaunts in ambulances over jolting pavements to far-distant hospitals.

The 16th and 17th wards have no hospitals. In the 17th ward alone we have 30,000 people, enough to constitute a city of importance. Over one-half are foreign-born, mostly Scandinavians, and more than one-third are under 21 years—our rising generation. And here, young ladies, is a pointer for you: there are 3,200 more males than females. An army of stalwart young men is encamped in the boarding houses in the eastern half of this ward.

The 17th ward is about a mile and a quarter square, bounded on the north and east by the river, on the south by Lake Street and on the west by May and Carpenter Streets. It contains eighty-five factories, half a dozen railroads, an elevated road and numerous street car lines with their many accidents. Our young Illinois Hospital is situated in the heart of this district on the six corners of Milwaukee and Austin Avenues and North Union Street. A cable car line passes the door and three other car lines are within a square. There is no other hospital nearer the center of this busy little world than two miles distant. The people are poor and need our help. The strong should lend a hand to the weak. It is good political economy to give aid to the ailing in time to restore their health, save their injured limbs and restore them to their vocations in the capacity of producers, rather than to allow them, through neglect, to become perpetual paupers, beggars or criminals. To a business man this is a proposition that appeals to good sense if not to sentiment. It is a paying investment for citizens to combine their efforts with the doctors' work in such humanitarian institutions. Physicians contribute their time, their talent and their strength, and as much money as they can afford. Is it just to ask them to go farther and bear the entire burden of these charities for the community whose duty it is to provide housing, board and nursing for their sick poor?

We have made a discovery in the 17th ward. We happened upon a determined little band of noble souls who had imposed upon themselves the duty of living in the midst of this colony for educational purposes. They are there as brothers and sisters to help those who need help, to teach those who want to learn, to promote cleanliness, purity and peace—in a word, to make intelligent, patriotic American citizens. Without sect or sectionalism they cultivate the spirit of universal brotherhood and practical Christianity. The founding of a dispensary and hospital in this neglected spot is due to the open arms that welcomed us to this self-sacrificing settlement—the Chicago Commons. Long life and success to the Chicago Commons! They need and merit your help. They are our willing allies. Our interests are mutual.

We appeal to the people to rally to our aid. The love of humanity should call forth the generosity of our fortunate few. The memory of Newberry, Crerar, Jones and Lewis shall live when their tombstones are no more. The high examples of Rockefeller and Field should not be lost on those who wish to witness the blessings of their benefactions while they live. Who will be our Scoville of great heart, and our Dr. Pearsons of many noble deeds? Or who will be our Mrs. Pearsons with her $10,000 gift to Anatolia College, presided over by my classmate?

Great souls are these—products of this century and this civilization—superior to any other! Their memory shall bloom when monuments crumble to dust. Their spirits shall animate the coming generations when their fellow-mortals sleep forgotten. What other benefactor of our race shall rise to bless his fellow-men? Who will sow the seeds of a lasting charity by endowing this refuge—this restorer of the helpless to health and happiness? And what more fitting place to appeal for brotherly love and sympathetic deeds than this platform, hallowed by that poetic preacher who dwelt like sunshine in our midst, consecrated to the cause of humanity and a broad Christianity, whose features, cast in classic mold, smile sweet benedictions on our cause—that moral philosopher and Christian philanthropist, David Swing!

ORIGINAL ARTICLES.

HISTORY OF THE CASE OF THE HON. WALTER Q. GRESHAM, LATE SECRETARY OF STATE OF THE UNITED STATES.

BY W. W. JOHNSTON, M.D.
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Secretary Gresham was taken ill on April 30, the earliest symptoms appearing while he was at a Cabinet meeting; on the following day he was suffering from acute epigastric pain, which was so severe as to require the use of morphia hypodermatically. On May 3 the pain changed its location to the right infra-axillary region. By reference to the thermometric chart it will be seen that during these days he had fever. At this time he was under the care of another physician.

Early on the morning of May 4, I received a note asking me to call and see Secretary Gresham at the Arlington. I was requested by him to take charge of his case. The chief symptoms which were presented to me, at my first visit, were fever, embarrassed breathing, his voice being broken during conversation, and his facial expression indicating suffering; the pulse was 100 and not very strong and his respirations were 36 to the minute. He had slept several hours during the night, but sleep had been much disturbed by the dyspnea and by acute pain in the right side.

Physical examination of the chest showed the presence of a considerable amount of fluid in the right pleural cavity, dullness on percussion and aegophony reaching as high as the lower edge of the scapula. There was diminished expansion and entire absence of vocal fremitus over the same region.

The diagnosis was made of acute pleurisy with effusion on the right side; this opinion was based upon the symptoms and physical signs described; there was no symptom, noted by me at the time, which could not be explained by this lesion, and there was no symptom which indicated any lesion of any of the abdominal viscera. Neither then nor at any subsequent period was there any icterus or abdominal tenderness, or unusual tympanitic distension.

A cantharidal plaster, six inches square, was applied over the right infra-scapular region, a liquid diet of koumiss and milk ordered and absolute rest enjoined. A mixture was prescribed containing the liquor ammoniæ acetatis and tincture of digitalis. He was already under the care of a trained nurse, another one was secured to assist, and everything was done for his general comfort under the watchful supervision of Mrs. Gresham.

During the day the patient slept at intervals, and there was a good deal of discomfort in breathing; he was unable to lie on either side, but his symptoms did not change for the worse. The blister had vesicated well; this was dressed and the right side covered with cotton and oiled silk.

May 5. After 1 A.M. the night was comfortable; his temperature continued to drop until it reached 99.2 degrees at 6 A.M. At 9 A.M. an attempt to turn over, brought on a violent paroxysm of pain in the right side of the chest; for a time he breathed with difficulty, but as soon as the pain passed off, he was in no sense any worse than before. A water enema was followed by a large normal movement. At the morning visit the line of dullness on percussion showed the fluid was greater in amount, the respiration had increased to 40 and the pulse to 118 per minute, these being the maxima reached during this period of the illness; during the latter part of the day he was more comfortable, and slept three hours at intervals. Milk, koumiss and chicken broth were taken alternately and the ammonia and digitalis mixture was given, but not regularly.

May 6. During the night the patient slept in short naps; at 7 A.M. there was profuse perspiration, the temperature then being 98.2 degrees and he was nervous and restless. Later in the morning he felt better than before; a water enema gave him a small normal action and in the afternoon he slept three hours. The pleural effusion reached its maximum to-day, the dullness extending nearly to the spine of the scapula, but the breathing was not over 30 to the minute, the pulse 98; the greater ease in breathing seemed to be due to the relief from the constant and aggravated paroxysmal pains in the pleura which had been present up to this day, and which after this did not recur.

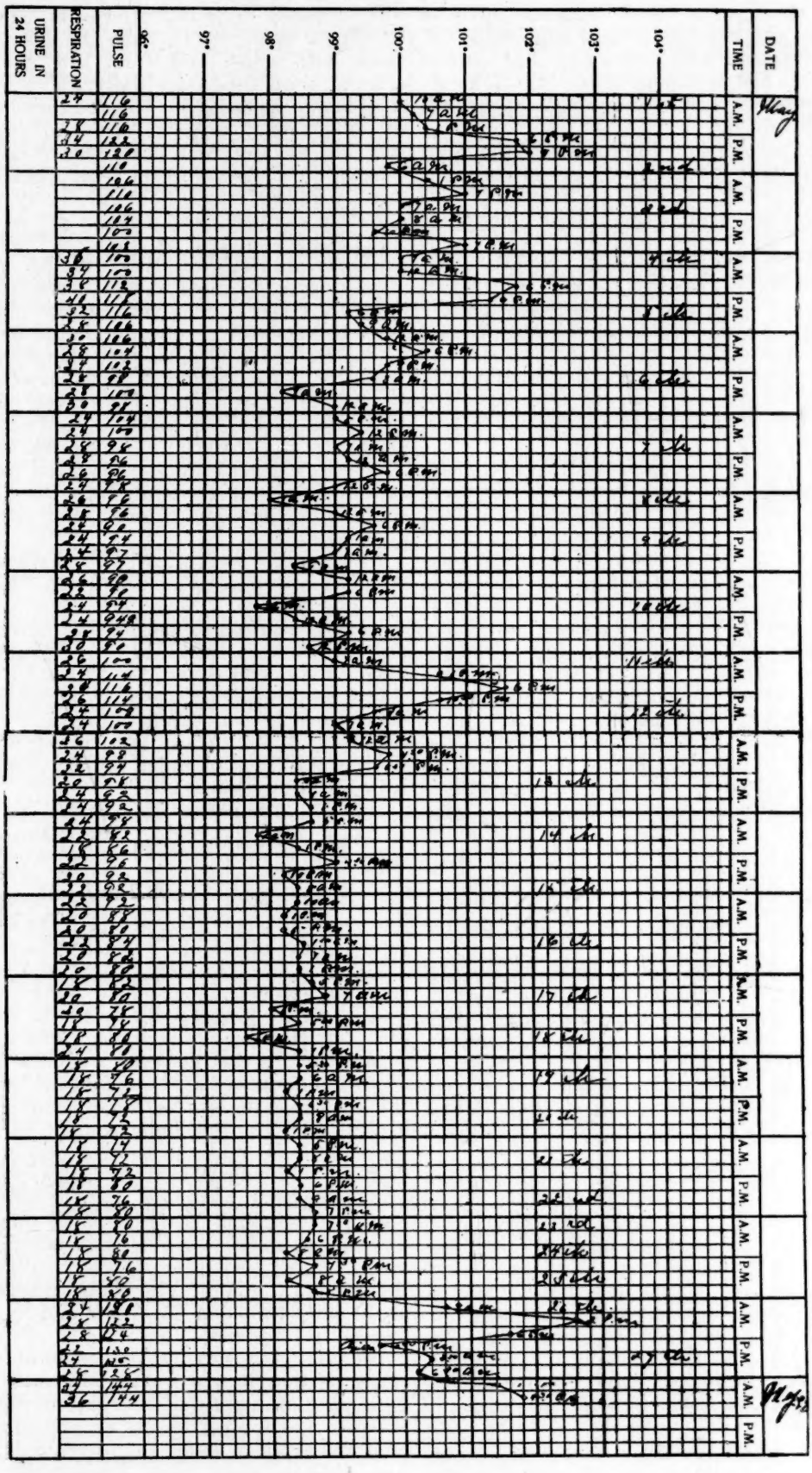
May 7. The patient slept moderately well during the night; in the early morning he was restless.

Mr. Gresham frequently, and generally in the morning, complained that he was suffering from indigestion, but there never was any objective evidence of this; his tongue was slightly coated and dry, and there were occasional eructations of gas, but as a rule digestion of the fluid food given was as well performed as it usually is in acute illness. During the day he had several short naps and seemed very comfortable, although he was at times anxious and nervous.

May 8. The patient slept between six and seven hours during the night, at times lying on his left side and breathing with no difficulty. He awoke

Transfusion mentioned on page 999 was made by Dr. Van Rensselaer.

RECORD OF TEMPERATURE, PULSE AND RESPIRATION, CASE OF SECRETARY GRESHAM.



much brighter than on any previous morning; his temperature was 98 degrees lower than at any previous time, his respirations were 26 and pulse 96. Three ounces of Hunyadi Janos water were given; as this had no effect, a water enema was administered later in the day and a small normal movement followed. The afternoon was comfortable but without sleep. The same diet was continued, but as he objected to the mixture and as he was doing so well this was discontinued.

There was no perceptible diminution of the fluid in the pleura, but no increase, and the general improvement and feeling of ease in breathing gave every encouragement of rapid absorption. The question of paracentesis was not considered, as no symptom called for operative interference.

May 9. The night was less comfortable than usual; he did not sleep well until between 2 and 7 in the morning. As he complained of indigestion, a powder of bismuth and bicarbonate of soda was given and later a water enema caused a small action. During the afternoon he slept at intervals; the nourishment of buttermilk or broth was taken regularly during the day.

May 10. The patient slept moderately well, but was disturbed by having two loose actions in the early morning. The morning and afternoon were passed comfortably; his food was relished more than at any previous times. As he complained of occasional and slight pain at the edge of the ribs on the right side, a small blister was applied to the right inframammary region and left until it caused vesication. To-day there was a perceptible beginning to the absorption of the effusion. All the symptoms were favorable, and beyond an occasional complaint of indigestion he spoke of nothing being wrong.

May 11. The daily decline in the temperature and the improvement in other symptoms had been uninterrupted up to this date. At 7 A.M. the temperature was higher than at any previous day at the same hour since May 5; it continued to rise during the day, reaching 101.6 degrees at 6 P.M.; from this hour it continued to drop until it reached 99 degrees at 7 A.M. on the next day. There was no apparent reason for this accidental interruption to the daily decline of the fever curve.

Dr. D. W. Prentiss met me in consultation and agreed with me as to the diagnosis and as to the favorable progress of the case; the pulse, respiration and temperature indicating a decline in the inflammation, and giving promise of early absorption of the fluid. A capsule of squills, digitalis and calomel was directed to be taken every four hours, and buttermilk, milk and Mellin's food or bouillon were given every two hours.

May 12. The night was very comfortable; there were several hours of sleep in the morning; as he wanted more food, tea and toast were given and, later, oyster broth. The temperature had fallen and he seemed to have recovered from the sudden rise of yesterday. Beyond an occasional sharp touch of pain on deep respiration there was no complaint today; the bowels were freely moved, and he was composed and cheerful. Although asking for the privilege of attending to business, he readily consented to give up everything that might delay his recovery.

May 13. From this date until May 25, there was a steady progress toward recovery from day to day. The fluid in the pleura rapidly diminished, the temperature was normal and the pulse and respiration reached 76 and 18 respectively. The tongue became almost entirely clean, and there was a demand for solid food to satisfy the increase in appetite. The diet consisted of milk, buttermilk, ragout, toast and breakfast hominy. On May 16, a small bird was taken with relish, and from this day on he was allowed solid food once daily, and semi-solids and liquids at other hours. Now and then he complained of indigestion, but his appetite and desire for food was not at any time lost; the condition of the tongue, the character of the fecal discharges and the usually quiet sleep at night gave every evidence that digestion was being well performed. As his improvement was so marked Dr. Prentiss discontinued his consultation visits on May 18. No medicine was given during this time except a capsule containing quinia and nux vomica three times daily. Two or three times the elixir of chloralamid was tried when he complained of sleeplessness at night.

May 24. The night was passed most comfortably; he enjoyed his breakfast of a tender piece of steak with toast, and his dinner of a bird and toast, milk and bread and buttermilk being given at other hours. The nurse's record states that "the day was most comfortable," and he slept during the afternoon. A solution of dilute hydrochloric acid with pepsin was given after food.

No privileges were allowed the patient beyond the permission to look at an illustrated periodical for a few moments at a time; occasionally he sat in a semi-erect position supported with pillows; the same precautions were continued in every other respect as during the earlier part of his illness. Except for one visit from his private secretary he saw no one except members of his immediate family, and he did not attempt to attend to any matters of business. His manner was that of quiet content and satisfaction with his improvement.

May 25. The patient slept well; the record says he had a very good night. The examination of the chest showed the presence of a very small amount of fluid in the lower part of the pleural cavity; aegophony had almost entirely disappeared, the line of dullness was much lowered and there was a distinct return of expansion and normal vocal fremitus.

The gain had been so marked in the past few days that the expectation was held out to Mr. Gresham that he might be able to sit up by the side of his bed for a few minutes within three or four days. On the evening of this day, however, a sudden change in his condition destroyed all these well-founded hopes, and the overwhelming illness began which ended fatally on May 28. The first indication of this change appeared at 7:30 P.M.; he seemed uncomfortable and restless, and complained of epigastric uneasiness which very soon became a decided pain. About 11 P.M. he vomited a little greenish fluid and a few coagula of milk which he had taken about three hours before; there was no other undigested food in the matters vomited. The temperature began to rise at the same time and the pulse and respirations increased in frequency.

May 26. At 1 A.M. the pain was of so intense a character that it was found necessary to give him one-eighth of a grain of morphia hypodermatically. Mustard was applied to the epigastrium and liquid food was given in small quantities only. The night was restless, sleep being interrupted, but toward

morning there was some improvement in the symptoms. He again vomited in the afternoon. The pulse was frequent, not very strong and occasionally irregular. Milk with whisky and beef juice were given. One other dose of morphia was administered at 6:40 P.M. to relieve a very intense attack of pain, but after this it was not again required.

During the night the pain passed to the left side of the chest wall, and it was thought the attack would prove to be one of pleurisy on that side; a small blister was applied over the left infra-mammary region. The increase in the respirations and pulse and the continuance of fever gave grounds for believing that there was some new inflammatory process beginning in the chest. The pain and vomiting were thought to be reflex symptoms due to this cause and the subsequent progress of the case and its termination confirmed this opinion.

May 27. During the night the pulse had much less force, and food and stimulation were continued. There was no vomiting until 10:30 A.M. when a considerable amount of greenish fluid was thrown off.

Dr. Prentiss met me in consultation and on examining the chest we discovered solidification in the recently expanded lung on the right side. There was a decided area of dullness, where the percussion had been almost normal two days before, and there was some bronchial breathing with bronchophony over the same area. The conclusion reached was that there had been an extension of the inflammatory process to the pulmonary tissue and that the symptoms present were due to pneumonia suddenly developed in the right lung.

The care which had been taken and the avoidance of any imprudence or exposure precluded the idea that this attack was the result of "catching cold;" the nature and course of the illness showed that it was not primarily connected with digestion and, therefore, not due to the indigestion of the food taken.

The alarming symptom was the weakness of the heart's action. During the morning the pulse ranged from 128 to 135; nitro-glycerin and digitalis were administered but with little effect in giving strength to the heart. Up to 6 o'clock in the afternoon there was no alarm felt as to any immediate danger; at this time the pulse became more frequent and feeble and the dyspnea was more marked. Strychnia and nitro-glycerin were given hypodermatically at regular intervals and stimulating enemata employed. At 9 P.M. there was such a marked collapse that death seemed imminent; transfusion with a sterilized saline solution was made into the median-cephalic vein of the right arm; three pints were introduced with the effect of bringing back warmth to the extremities and some color to the face, the pulse also became fuller and stronger; but this effect was temporary only and by 11 o'clock the same symptoms of collapse returned. From this time the change was rapid. Consciousness was not altered until within a short time of the last moment. Death occurred at 1:15 A.M., May 28.

Bellevue Hospital, New York.—The Commissioners of Charities and Correction of New York City have determined to introduce the novelty of Turkish and Russian baths into that institution. Bids thereon are to be opened June 27, and the work will be pushed.

NOTES OF A CASE OF ACUTE SUPPURATIVE PANCREATITIS WITH REPORT OF NECROPSY.

Read in the Section on Practice of Medicine, at the Forty-sixth Annual Meeting of the American Medical Association, at Baltimore, Md., May 7-10, 1895.

BY I. E. ATKINSON, M.D.

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Acute suppurative inflammation of the pancreas is so rarely recognized during the lifetime of the paient, that I have thought that the details of the following case, in which it was possible to make a correct diagnosis while the patient was yet alive, would prove sufficiently interesting to engage your attention for a few moments.

I was called to see, on Dec. 2, 1894, Mrs. S., the mother of two children, one 12 years, the other six months old. She was 35 years of age, with dark hair and eyes, tall and unusually stout, though it was thought she had lost nearly forty pounds during her illness. She had enjoyed excellent health until fifteen months previously when she was seized with a severe attack of what her physician told her was hepatic colic, and which was followed by intense jaundice within two days. The attack lasted three weeks, with the usual symptoms. No gall stone was recovered from the feces, though looked for. The pain was almost constant, though of unequal severity. After a very severe paroxysm it disappeared abruptly and the patient soon regained her health. She became pregnant almost immediately after, nearly eleven years after her first and only other pregnancy. She was safely delivered last June, did not nurse her baby and made a good convalescence. In August she was thrown over the dashboard of a dog-cart but was apparently unhurt. During the summer, for a month or more, was affected with slight diarrhea. Upon the last day of September she was suddenly seized with an attack which she recognized as identical in character with her former attack of hepatic colic. After two days, her urine became dark, her stools colorless, and jaundice supervened. Her pain was almost incessant though she did not take to her bed. After a while the intervals between the paroxysms of pain became longer, but no positive relief in its intensity was obtained, though the jaundice diminished and her feces became colored again. She continued to lose weight, her appetite and strength failed and she finally took to her bed, about four weeks previous to my first visit. The various remedies employed under medical advice gave only temporary and partial relief. Since taking to bed, she had had no sharp paroxysms of colicky pains, but had had frequently recurring milder pain, with persistent, though slight jaundice, and frequent vomiting, the ejected matter occasionally being streaked with blood.

At the date of my first visit, sixty-two days after the beginning of the attack, she was in bed, slightly jaundiced; her body was still well nourished. Her tongue was coated with a thin yellowish fur. She had no sore throat. The heart and lungs gave no abnormal sign. There was no expectoration and no cough. She was vomiting several times daily, almost without nausea, a greenish fluid, sometimes slightly bloody. The vomiting appeared to have no relation to the ingesta. The bowels were moved several times daily. The actions were semi-solid, grayish, and

contained lumps of mucus. This mild diarrhea and vomiting were said to have been present for several weeks. Hiccough had latterly been very troublesome. There was no splenic enlargement. Liver dullness began in the mammary line at the first rib, but did not extend beyond the costal arch. The body was somewhat distended with gas. In the epigastric region, extending into the left hypochondrium and reaching to within an inch and a half of the navel, was an induration, not modifying the outline of the abdominal wall, irregular in contour, not fluctuating, not movable, and but slightly tender to pressure; its diameter in the median line was about three inches and four and a half inches laterally, reaching to left mammary line. The percussion note over this tumor was relatively dull, not tympanitic. The lower abdomen showed no abnormality. The urine was abundant, darkened by bile pigment and faintly albuminous and with Fehling's solution gave a slight but positive sugar reaction. It was acid and of sp. gr. 1020. Though almost no pain was elicited by palpation, the patient complained of severe lancinating paroxysmal pain radiating from the epigastric region, with its point of greatest intensity under the xyphoid cartilage. She also suffered similar pain in the back, between the shoulders. The abdominal muscles remained almost motionless during respiration, which was almost purely costal and rapid, significantly so when considered with reference to the pulse rate and in the absence of signs of pulmonary disorder. Fever was said to have been present for many weeks, though recorded observations were not made until November 27. During the entire period of illness there had been no chill. Several weeks previously there had been a sensation of chilliness, but this had never recurred. Neither had there been sweating, except to a small extent about the head. She had at no time had symptoms of intestinal obstruction; on the contrary, there had been a notable tendency toward diarrhea almost constantly from the first. She was unable to lie upon either side and was most comfortable in a semi-recumbent, dorsal position. Exhaustion was great and sleep very insufficient and disturbed. An hour after my examination she vomited some fresh blood.

A consideration of all the symptoms and history seemed to justify the following diagnosis: hepatic colic at the outset of symptoms on September 30; impaction of the calculus at the common orifices of biliary and pancreatic ducts in the duodenum with incomplete obstruction. Inflammatory hyperemia with gradual formation of suppurative pancreatitis and peri-pancreatitis. The case progressed with varying but increasingly graver symptoms. The tumor gradually extended downward to the level of the navel. Diarrhea became very unmanageable, the stool assuming a thin grayish or greenish-gray, or yellowish, occasionally dark character. Free fat was never detected in them, though sought for diligently. Vomiting was also extremely distressing and constant, though often performed without nausea. Microscopic examination of vomited matters gave no information as relating to the nature of the essential trouble. They were largely made up of greenish mucus, often containing blood, or were often composed almost entirely of ingesta. Treatment, both of diarrhea and vomiting produced only temporary effect. There was complete anorexia. In spite of supporting and anodyne treatment the physical condition steadily deteriorated, and on December 12 Professor Tiffany was called in consultation with a view to operative interference. While agreeing in the main with the diagnosis as given, Professor Tiffany in view of the general condition did not feel justified in operating. Diarrhea, vomiting and paroxysmal pain now became very distressing and the patient was kept constantly mildly under the influence of morphin, hypodermically administered. The tumor remained hard, irregular, and gave no sign of fluctuation. Tympanitis had noticeably increased on the 14th, and upon that date a noticeable fall of evening temperature was observed, but there was no increase of abdominal tenderness, though paroxysms of pain were frequent and severe whenever the effects of the morphin became weakened. On the 16th, cough developed and crepitation was heard at the base of the right lung. On the 18th at 8:45 o'clock she became very weak, the face, feet and hands cold, the respiration slow. She rallied slightly after a while and during the day had four dark green stools. On the 19th, at 9:45 o'clock A. M. she passed a copious stool consisting entirely of bloody pus. During the day she had several similar stools. At the same time the tumor became indistinct and noticeably smaller. She sank rapidly and died in collapse at 5 P. M. The course of the pulse, temperature and respiration and the extent of diarrhea are shown in the accompanying chart, which, however, dates only from the fifty-eighth day of the disease.

Post-mortem examination, by Dr. K. B. Batchelor, twenty hours after death. (Examination of abdomen only.) Abdomen distended and tympanitic. On opening abdominal cavity a large quantity of foul-smelling gas escaped with something of an explosion. Gas continued to escape for some seconds. Greater omentum contained a quantity of fat. There are multiple fresh adhesions between omentum and parietal peritoneum in superior portion of abdominal cavity, and there is also, here, very slight congestion in peritoneum. No fluid in peritoneal cavity. The adhesions (fine fibrous bands) are easily broken down and separated in right superior portion of omentum and peritoneal cavity. Toward the left side they gradually increase in number and size, but are easily separated everywhere.

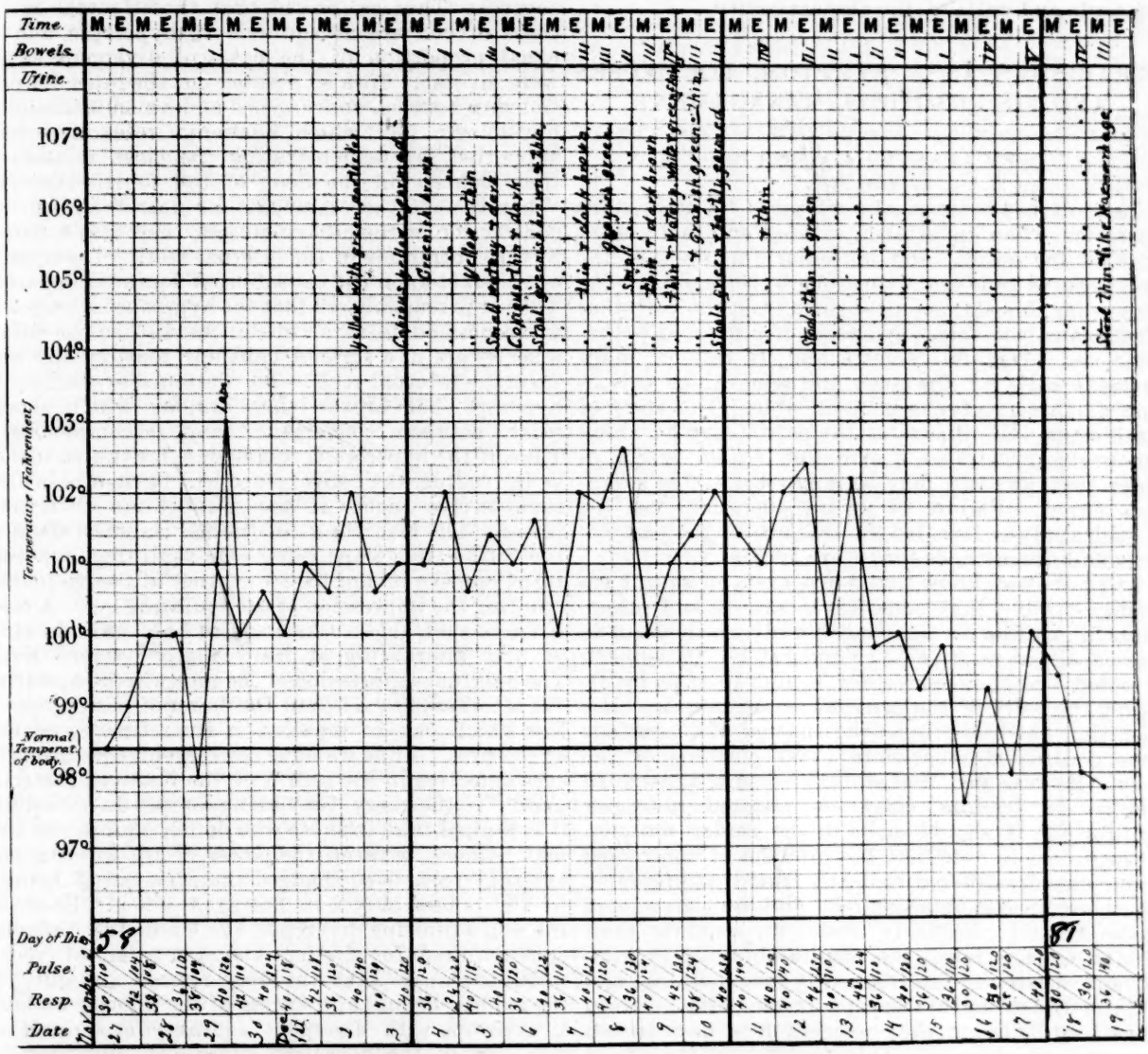
Areas of fat necrosis are found in great numbers in left upper side of omentum, over the abscess cavity. None are found on right side. The inferior portion of omentum is free from adhesions or fat necrosis. The posterior surface of the omentum and the transverse meso-colon are much congested and covered with recent fibrous adhesions. The intestines in superior portion of abdominal cavity are tied together by numerous fresh adhesions. They are easily separated.

Stomach shows nothing abnormal. The head of the pancreas is almost entirely obliterated, the part remaining forming a portion of the posterior wall of the pus cavity. This cavity occupies the position usually occupied by the pancreas, together with the whole of the lesser omental cavity. Its walls are shreddy and have a spongy, worm-eaten appearance. The cavity extends upward behind the stomach to the vault of the diaphragm, the inferior surface of the diaphragm being covered, to a less extent, with the shreddy and spongy lining of the pus cavity. Situated about the center of the lower portion of this cavity is a small remaining part of the pancreas. It

also is spongy and worm-eaten in appearance, and readily breaks down on pressure. Its meshes are filled with the contents of this cavity. It is connected to the wall of the cavity by a narrow pedicle. The cavity is filled with a thick, dark, reddish-brown, greasy-looking, very ill-smelling fluid, which is also greasy to the touch. On microscopic examination it is found to be composed of pus corpuscles, red blood cells, fat cells and granular detritus.

An opening is found on the inside of the descending portion of duodenum (side next to abscess cavity) about the site of the opening of the common duct. It has very ragged edges. The source of the gas in the peritoneal cavity was not discovered. None of the contents of the abscess had escaped into the larger peritoneal cavity. The peritonitis, which was very recent, had evidently begun during the last days of life, probably on the 14th, when the sudden fall of temperature occurred, as shown in the chart. It is interesting that its development was not accompanied by any increase of abdominal tenderness. The rupture of the abscess probably occurred upon the day preceding death and was synchronous with the remarkable diminution in size and definiteness of the abdominal tumor.

According to Fitz, whose classical writings upon acute pancreatic inflammations have done so much to render their clinical study definite, three varieties of acute pancreatitis are encountered: hemorrhagic, gangrenous and suppurative. Mild and favorable cases of hemorrhagic pancreatitis have not been detected during life, but post-mortem observation appears to prove that they may occur. Should death, in the more severe cases, not take place within the first week the inflammation merges into the gangrenous form, which seems an almost invariably fatal course in from three to eight weeks. Recovery may occur spontaneously; the sloughing pancreas having been discharged through the bowels or after surgical operation.



Suppurative pancreatitis, Fitz separates from the two preceding forms. Not associated with hemorrhage or gangrene, its tendency is toward pus formation and death in from a few weeks to a year. A case recently reported by Thayer, however, shows that surgical interference, following early recognition of the disorder, may be expected to reduce the death rate materially (Bulletin of the Johns Hopkins Hospital, February, 1895), and though the clinical diagnosis of either form of acute pancreatitis

has, heretofore, been wellnigh impossible, it may be hoped reasonably, that the more definite knowledge of their clinical history and symptomatology that we now possess will insure its very much more frequent recognition. The case that I have the honor to report presented characteristics that rendered an accurate diagnosis fairly easy to any one reasonably familiar with recent literature upon the subject. More exact acquaintance with acute pancreatitis, however, will probably reveal frequent inter-relations of all three varieties mentioned. My own case, for example, presented indisputable proofs of an antecedent hemorrhagic condition, as shown in the presence of blood cells and coloring matter in the contents and walls of the abscess cavity.

STRABISMUS AS A SYMPTOM, ITS CAUSES AND ITS PRACTICAL MANAGEMENT.

Read before the Michigan State Medical Society, June 7, 1895.

BY LEARTUS CONNOR, M.D.
DETROIT, MICH.

Landolt in his classical work says: "A strabismus operation, when undertaken without an exact knowledge of the optical and muscular functions of the eye, is but a rude and dangerous experiment." The reason for this statement springs from the fact that strabismus is merely a symptom of numerous pathologic and congenital defects, and its rational management calls for the study and removal, or correction of these, so far as is practicable. The story of strabismus well illustrates the persistency by which the profession traces a symptom to its origin, in order that its cause may be removed and the symptom cured. Failure of squint operations has led to such study as revealed the reasons for the past defects and the methods for future success.

At present we know that some cases of squint are readily curable, that some are incurable, and others doubtful, calling for additional study ere they can be classed either as curable or incurable. Diefenbach operated first for convergent squint in 1839, by dividing the belly of the internal rectus muscle. His operation was based upon the analogy of operations upon contracted muscles in other portions of the body. He reasoned, that since division of contracted muscles or tendons elsewhere, restored muscular equilibrium, it should do so in the ocular muscles. He neglected to note that the problem of contracted ocular muscles differed radically from that presented elsewhere, in that opposing recti and their associated elastic tissues constantly tended to separate their divided ends. Hence the results obtained by himself and others were so frequently disappointing and actually disastrous that, except for the radical change introduced by Bohm, the operation must have passed into merited oblivion. This transferred the site of the operation from the belly of the muscle to its tendinous insertion, thus leaving the capsule of Tenon mainly undisturbed. The technique of the operation was so perfected by von Graefe as to render it easy and safe of performance; especially useful was his method for either increasing the effects of a tenotomy or diminishing the same.

The ophthalmoscope enabled us to see that some cases of squint were due to diseases of the refractive portions of the eye, distorting the passage of the rays of light in their course to and from the retina, or, as in case of disease of the optic nerve, cutting off the power of transmitting the impression made by the rays of light upon the retina, to the brain.

Not a few cases were traced to corneal opacities. Eyes entirely blind were found to often squint. Thus the symptom squint was traced to a variety of pathologic conditions, having one common feature, viz., they rendered the vision of the two eyes unequal and so deprived them of the "guiding sensation." With these facts in mind it is clear that a squint operation, without previous careful ophthalmoscopic examination, must be "a rude and dangerous experiment."

Donders' studies of refraction and accommodation traced this symptom to other and more common sources. Thus he showed that three-fourths of the cases of convergent squint were hyperopic, and an equal proportion of the cases of divergent squint were myopic. He also pointed out the intimate relationship between convergence and accommodation, a physiologic fact which anatomic researches have supported, by demonstrating the close relation of their centers in the floor of the fourth ventricle. When the eyes accommodate for near objects by the contraction of the ciliary muscle, they also converge by the contraction of the internal recti. The bearing of this fact upon the causation of squint is apparent, when it is remembered that the hyperope is compelled to accommodate at all distances, and so the ciliary muscles are in a state of constant tension, and with them the internal recti. The flattened eyeball of the hyperope has broken the harmony which should exist between convergence and accommodation. Thus, if the hyperope accommodate for twelve inches, as in reading, the convergence will be at a point less than twelve inches if the muscles are of normal power. The result is a diffusion of impressions upon the retinæ, to escape which the squinting hyperope turns one eye in and fixes the other at twelve inches, ignoring the impression of the squinting eye. A repetition of such acts forms a squint habit, which, while at first alternating, at last usually becomes fixed. The habitual suppression of the image in the squinting eye is followed by a loss of the power of perception—a loss which can be repaired if the retinæ be normal at the first. Thus we have convergent squint due to eyes defective in the length of their antero-posterior axes. To the query, Why all hyperopes do not squint, it is replied that in those who do not squint, the normal balance between the power of the internal and external recti is so changed that, instead of being 4 to 1 it is less, only 2 to 1 or even 1 to 1. Hence in the non-squinting hyeropes, the excessive convergence required for distinct vision is balanced by the weak interni, so that the eyes remain straight. If the externi be much in excess of the interni, we have a hyperope with divergent squint. In support of this view of the causation of squint, advanced by Valk, I have habitually found all hyperopes to have weakened interni, as measured by the standard of 4 to 1.

Donders found that myopes needed little or no accommodation, because the eyeballs were already too long; hence the convergence in near seeing would be *nil*, and so if the strength of the recti was normal, the eyes would turn outward and give a divergent squint. But if the externi were weak the eyes might remain straight, or if very weak they might turn in and give a convergent squint. Aside from muscular action in causing divergent squint in myopes, we

have the elongated antero-posterior shape of the eyeball; the greater distance between the temples of myopes; variations of the orbital fat, and of the attachments of the ocular muscles to the bony walls.

These studies in refraction, accommodation and action of the external muscles of the eyes have led to far reaching consequences in the management of the symptom of squint. Thus it has shown that some cases of convergent squint can be permanently cured by the wearing of such convex glasses as fully correct the abnormal flatness of the eyeballs; that some cases of divergent squint can be cured by the wearing of concave glasses, which reduce the refractive power of the eyes to their normal standard. The symptom disappears when we have restored the lost equilibrium between the refraction, ciliary and recti muscles.

As the nature of mydriatics became understood, it was found that their use in paralyzing the accommodation, permitted the recti to assume their normal functions, and so facilitated a cure of cases in which the squint persisted after the defects of refraction had been corrected by appropriate glasses.

Statistics on a large scale, show that while tenotomies and advancements cured many cases of squint, the intelligent correction of refractive defects and the use of mydriatics cured many additional cases, added to the number of those who secured binocular vision and diminished the number of divergent squints following tenotomies. Thus by distinct lines of evidence we have traced the symptom squint, in many cases to defects of refraction, and abnormal ocular muscles. This result is still further confirmed by recent studies of those similar disturbances of muscular equilibrium known as insufficiencies or heterophorias. These studies have encouraged surgeons to seek binocular vision in the management of squint, rather than rest content with the straightening of the eyes, because they have given us finer and more precise methods of operating and more suitable instruments, both for determining the muscular disability and for doing the operations; in short, they have furnished us with a micrometer adjustment for the doing of squint operations, and so raised them to a higher perfection.

Finally, squint has been traced to a defective structure of the retinal percipient elements, congenital in its origin, unchangeable in character, and causing an inability to see other than large objects. Upon these eyes, neither glasses, atropin, or tenotomies have other than a cosmetic effect; only operative procedures avail aught in their management.

Having collected all existing knowledge respecting squint, we see still vast fields, uncultivated fields adequate for the surplus energies of more than a generation of physicians. Thus we want a comparative study of the origins and insertions and other relations of the ocular muscles; the modifications of their activities by the varied shapes and sizes of the eyeballs, by the individual peculiarities of the capsule of Tenon, by the quantity and quality of the orbital fat or the fibrous stroma which holds it in place. We want a comparative study of the orbital walls, as bearing upon their contents, and the functional activities of the eyes. We have still much to learn of the nervous apparatus of the eye and its muscles, of its visual and motor centers, and of the complex relationship of this apparatus to other organs; in fact, time fails us to even enumerate the fields awaiting investigation, in their relation to the causation and management of squint. However, our present knowledge enables us to attain very satisfactory results in an increasing number of cases. It is a marked advance in that we aim, not only to straighten eyes, but to have the patient possess binocular vision. This is attained by supplementing the operations for squint with gymnastic exercises, innervation treatment or partial tenotomies, until we have enabled the eyes to fix upon any point within the visual field. This necessitates a cordial coöperation of physician and patient during an extended period, varying with individual cases.

For convenience, the management of squint may be divided into operative and non-operative. The operative measures are tenotomies of the stronger muscles or advancement of the weaker ones; both of which may be needed in the same case.

The non-operative means are:

1. Careful attention to the patient's constitutional condition.

2. The correction of all defects of refraction, so far as these affect the squint unfavorably—the correction to be made from data obtained while the eyes are fully under the influence of atropin.

3. The continued use of mydriatics.

4. The use of gymnastic exercises, or the innervation treatment of Gould, to increase the power of the weaker muscles, or to bring them into coöperation with the stronger.

In each case the surgeon is met with the question, Is this an operable one? To aid in answering this, I give brief extracts of four typical cases, whose condition I was able to record many years after the treatment—affording the final results of the management of convergent squint:

Case 1.—Boy aged 5, strong, with marked convergent squint of the left eye, noticed when six months old. An examination with the ophthalmoscope showed a healthy ocular media; vision of right eye was 20-20; of the left 20-200. Under a mydriatic the ophthalmoscope showed a hyperopia of a dioptric and a half. The full correction of this was prescribed, and the ciliary muscles kept fully under the influence of atropin, but at the end of six months the result was negative. The internal rectus tendon was now divided and the other treatment continued, with the final result of leaving the eyes perfectly straight, but with no improvement of vision even fifteen years after the tenotomy. This was clearly an operable case, as nothing but the tenotomy changed the squint, and even it failed to improve the vision. Such cases are defective in the percipient elements of the retina of the squinting eye, or its optic nerve relations.

Case 2.—A healthy girl aged 9; convergent squint of right eye since 1 year old, at first alternating but finally fixing; the ophthalmoscope showed perfectly healthy media, in both eyes, and a hyperopia of two dioptrics in the right eye and one and a half in the left; vision of right eye was 20-200; of left eye 20-40. Full mydriasis and correction of hyperopia failed to benefit the squint, so that a tenotomy of the right internal rectus tendon was done. This failing, a month later the left internal rectus tendon was divided, with the result of making the eyes practically straight and after many months bringing the vision of each eye to 20-20. These two cases were alike in both requiring ocular tenotomy, but unlike in that the vision of the first was unimproved, while that of the second became normal, though the same methods were employed. The first represents a class of cases, congenitally defective in the percipient elements of one eye and so incapable of development; the second stands for a class in which vision is lost by non-use, but can be restored if the eye can be placed in such relations as will admit of the normal exercise of the retinal elements.

Case 3.—Boy aged 5; squint noticed when 2 years old; alternating then and at examination; vision of each eye 20-40; hyperopia two dioptrics, the correction of which gave a vision of 20-20, and rendered the eyes perfectly straight.

Atropin was used six months and the correcting glasses worn constantly, with the result that ten years later the eyes were straight and the vision binocular and normal.

Case 4.—Boy aged 8; convergent squint of the left eye, noticed when year and a half old as alternating but now fully fixed; ophthalmoscope revealed perfectly clear media, and a hyperopia in the right eye of two dioptrics, and in the left of two and a half; vision of right eye 20-30; of the left 20-100. Glasses correcting the hyperopia, both straightened the eyes and substantially improved the vision of the fixed eye. This improvement continued till vision of the squinting eye was equal to that of the other, and nine years later the vision continued normal and the eyes perfectly straight.

The last two cases were clearly non-operable. True, a tenotomy would have rendered the eyes straight, but later they would have diverged.

To avoid complexity, simple hyperopic cases are selected, but cases of hyperopic astigmatism, simple or complicated with hyperopia obey the same laws.

It follows that in every case of uncomplicated squint, the question arises, Does it belong to the class of congenital amblyopias or no? If the answer be affirmative, the case can be operated upon at once for cosmetic effect—there being no hope of improving vision. If the answer be negative, we must separate the operable from the other cases. The following has been found a safe method of procedure:

1. Eliminate all cases of paralysis.

2. With the ophthalmoscope, detect all squints due to opacities in the refracting media and treat them by operations, as in congenital amblyopias, for cosmetic effect merely.

3. Determine the vision of each eye, and the kind and degree of ametropia under mydriasis.

4. Correct the full amount of ametropia, and if this renders the eyes nearly or quite straight, an operation is inadmissible and the cases will probably go on to full recovery, under the use of glasses and atropia.

5. If glasses and atropin produce no perceptible effect upon the squint, then a tenotomy of one or both recti is indicated, followed by the use of glasses to relieve the eye strain and retain the eyes in the position resulting from the operation. The securing of binocular vision in this class of cases is materially aided by gymnastic training of the weaker muscles, and the coöperation of all.

6. The time for operating upon convergent squint depends entirely upon the ability of the surgeon to separate the operable from the non-operable cases. An operable case is best treated as early as the coöperation of the patient can be assured—usually at about 6 years.

7. If glasses correcting the full ametropia be worn at an early date, the normal relations of convergence and accommodation are soon established, better developed during child growth, and the ultimate vision more perfect.

8. To secure the best results, calls for much attention to the management of these cases, during a period extending over months or even years.

9. As to the final balance of the internal to the external recti, a proportion of 4 to 1 has given the greatest comfort to patients, and the best vision under all circumstances.

CONCLUSIONS.

1. Strabismus is always a symptom of some morbid or congenital defect.

2. Success in its relief, has increased in direct proportion to our knowledge of these conditions and defects.

3. Strabismus due to opacities of the refracting media or to congenital amblyopia, can only be treated by operations, and solely for cosmetic effect.

4. Strabismus due to the combined action of hyperopia and normal recti, is treated by tenotomy or advancement, atropin mydriasis, suitable glasses and gymnastic or innervation exercises.

5. Binocular vision is to be sought for in all cases other than those due to opacities of the refracting media, congenital amblyopia or organic disease of the retina or optic nerve. With sufficient perseverance, it is attainable in a fair proportion of cases.

6. Recent studies of heterophorias afford substantial aid in the better management of squint, by the new standards of both operative and gymnastic work, by the more convenient and reliable instruments for examination, and finer ones for operation.

7. There yet remain a number of cases of squint not explicable by our present knowledge, or amenable to treatment by accepted methods. To bring these under definite law, both as to cause and management, remains for the student of ophthalmology.

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CONSERVATIVE BRAIN SURGERY.

BY S. V. CLEVENGER, M.D.
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In "Lectures on Intracranial Surgery," published in this JOURNAL, June 8, 1895, by Dr. Emory Lanphear, certain statements are made that are not warranted by pathologic and alienistic knowledge, certain operations are recorded as having been performed that are not justified by the literature or experience of those most competent to judge; and the results of the operations being unfavorable, and in some instances causing death, the conclusions of the paper alluded to are improper, and if recklessly absorbed and acted upon by others may be productive of further discreditable surgical interferences, and revolt of the laity against "butchery," as many unsuccessful operations are styled, even when these are judiciously and justifiably done.

That Dr. Lanphear is a "brilliant operator" is well known, but when this ability is unassociated with other requisites it is like pyrotechnics near a powder magazine. He speaks of "insanity from softening of the brain." He can not find such an expression in any work on insanity worthy of the name. At this date, to speak of "softening of the brain" as any kind of insanity, would place the physician who used the term upon the level of the public, untrained in any kind of medical information. "Softening" is not an initial lesion, but merely a consequence, and where found associated with cerebral defects, mental, motor or sensory, it is subsequent to hemorrhage, compression, contusion, plugging of arteries or veins that originated such defects. Extensive softening may exist without insanity, and often, when found in the brains of the insane, is not related to the insanity in the remotest degree.

Trephining to relieve compression of a cortical, or even to reach a reasonably accessible subcortical neoplasm, either of meningeal or neurogliar origin, or to raise a depressed piece of bone, or remove an exostosis, or to evacuate an abscess that can be reached without running the risk of murder, no one should find fault with, but when it is proposed to open the brain for an embolism situated usually near the cerebral base, most often in some Sylvian artery branch,

an embolism that may be resorbed if nothing whatever is done, is surgery worthy of the Middle Ages.

Dr. Lanphear is surprised that he "can find no published reports of operations for epileptic insanity," and supplies the void by telling of two cases operated upon by Dr. A. B. Shaw, both of which availed nothing. This operation for "insanity from softening of the brain—complete relief," describes an aphasic who had a few symptoms of traumatic insanity and who consented to the operation. "He was discharged in excellent condition, mentally and physically." It is too bad that no statement of his *present* condition three years after the operation is afforded us. It is safe to assert that, if living, the patient is worse than before the interference, not necessarily from the operation, but from the natural unrelieved course of such derangements.

The Doctor quotes an author whose reputation is quasi-scientific and popular — Maudsley, on the "Pathology of General Paresis" (paretic dementia): "Morbid adhesions of inflammatory origin, slowly spreading between the cortex and its investing membranes," and says: "If, then, by surgical means, we can arrest the spread of the trouble while it still involves that part of the brain which presides over," etc., etc. Ten years ago Spitzka, in his "Manual of Insanity" elaborated the pathologic anatomy of paretic dementia, and such conditions as Dr. Lanphear quotes from Maudsley are not mentioned, but other things are, such as intense degenerative processes in the brain and cord, pial adhesions to the cortex, cystic degeneration of the cortex, sclerosed and obliterated blood vessels, granular change in the ventricle endyma, the nerve cell degeneration and formation of the "spider-shaped cells of Meynert," the most constant and intense changes being *in the pons and medulla oblongata*, sclerosis of the cortical vessels, kinked, distorted, aneurysmal, plugged vascular channels, and, in short, "there is scarcely a ganglion or fiber tract that may not be affected." (Spitzka p. 228). Or, take the older English work of Mickle, "General Paralysis of the Insane," with the specified individual autopsies showing extensive general brain alterations, and the quotation from Maudsley becomes insignificant as a pathologic suggestion for cerebral surgery; as well attempt the diversion of Niagara River by opening a faucet.

Remember, also, that remissions of weeks or months and, in extremely rare cases, of years, have occurred in paretic dementia histories, and the temporary improvements after operations in a few cases may be accounted for. The reduction of one case to dementia proper by trephining can scarcely be called a success, for such an interpretation we can place upon Rey's case, which "afterward remained calm and quiet." . . . . "The subsequent history is unknown." One can be "quieted" with a brick. In another, "there was great improvement but the patient died in six weeks." In this case there was *cerebral atrophy*. How could trephining be expected to relieve atrophy of the brain?

As for syphilitic insanity, common sense would suggest a fair trial of K. I. before operating to relieve gummatous membranes. He says: "Manifestly, some of them can be readily removed by the knife." But how about those which can not?

Under the head of "syphilitic insanity," the Doctor narrates an epileptic insanity case, not considering that both these psychoses have separate and distinct clinical peculiarities. The operation "was characterized as a gross outrage" by the asylum physician; the patient died nine months afterward. "Had an operation been performed upon the right side of the head, subsequent to the one upon the left, the probabilities are that cure might have resulted." By what reasoning does Dr. Lanphear arrive at this conclusion? If removal of the "greater portion of the left parietal bone" was not sufficient, why, in the absence of any focal indications should the right also be removed, any more than the frontal and occipital? Unchecked, unchallenged, our "brilliant operators" will be removing the temporals and sphenoids next.

The quotation from Horsley is misapplied. Remove an affected area by all means, if well made out by focal or other definite symptoms to be in an accessible part, but for diffuse syphilis of the brain, or idiopathic epilepsy, in most cases, it is little short of homicide to attempt cerebral surgery where the operation becomes but an aggravation of inflammatory or allied states, beyond reach, as multiple gummata are likely to be.

Burkhardt's six cases of paranoia are cited. A fanciful psychology of the association paths of the brain was invented to warrant the cutting. "Ideogenic areas" are familiarly mentioned as though definitely localized. "A portion of the frontal and parietal lobes before and behind the ascending convolutions were removed with very satisfactory results in one case." What the "very satisfactory results" were, are not mentioned. "The other died from convulsions on the sixth day." "Satisfactory results" were obtained in three other cases. In one, "recovery from the paranoia was perfect."

The imperfect record in most of these cases, the ambiguity as to the effects of the operations, the neglect of detailed accounts of the condition of the patients for any period, short or long, after the surgery, and the general "altogetherness" the *tout ensemble*, reminds one of "Alice in Wonderland" narratives, written to startle and entertain, rather than to contribute seriously to science.

The Doctor's twelve rules seem to have been hastily written. The importance of the errors in them make it necessary to call attention to the dangers of following such blind leadership.

"RULES FOR TREPHINING FOR INSANITY.

"1. Every depressed fracture of the skull should be subjected to operation at the time of the accident, regardless of the amount of depression and irrespective of pressure symptoms."

This rule might apply to any case of obvious fracture. Insanity is rarely demonstrable immediately after a fracture of the skull.

"2. Every case of prolonged unconsciousness following a blow in the frontal region should be trephined for exploratory purposes; upon both sides, if necessary."

How long is "prolonged?" Ordinary cerebral concussion may be attended with prolonged unconsciousness and the occipital region may be injured by a frontal blow. It might be brilliant to trephine over *contre-coup* locations. The removal of the entire skull would be thoroughly exploratory.

"3. The skull should be opened in all cases of insanity dependent upon trauma, at the earliest possible moment after development of the mental symptoms."

Symptoms usually develop in such cases many years after the injury. Should the mental part of the brain be opened up, and if so where is it? When insanity supervenes from trauma the brain, in the vast majority of cases, has undergone permanent change without definite localization. What good would opening the skull do, aside from making a fee?

"4. Operation is justifiable in every case of serious suspicion of tumor, abscess, or softening of the frontal (or any other accessible) region."

Stet, with the exception of the word "every," which is too sweeping.

5. "Operation is advisable in every insanity following cerebral or meningeal hemorrhage in which localization is possible, the clot accessible and the mental trouble of recent development."

Such combinations are extremely rare, and there is nothing in medical or surgical literature to cause enthusiasm over trephining cases of cerebral hemorrhage. The suspicion attaches that death has been precipitated by many such operations, while expectant treatment has been rewarded by a fair number of recoveries, and a large number of partial recoveries. Sometimes the operation has restarted a deep-seated hemorrhage and the usual inability to differentiate cortical from basilar or subcortical and inaccessible recent ruptures of vessels make the operation exploratory, which, of itself, is adding to a trouble without reasonable certainty or assurance of benefit. The chances for aggravation by trephining outweigh the possibilities of relieving.

"6. Every case of insanity developing in the history of otitis media suppurativa deserves immediate exposure of the favorite site of cerebral abscess."

In fact, the simple operation of taking away the temporal bone or a large part of it. Exploration of the middle ear, the mastoid cells and a careful study of the case had better precede opening the temporal region. The bones may be found carious, an abscess may be evacuated in that neighborhood, but the chances are that an extensive meningo-encephalitis is the pathologic condition, in which case less harsh measures would be of more avail, and decidedly less dangerous.

"7. Trephining for the purpose of breaking up adhesions of an old meningitis has been successfully practiced though it is not to be strongly advised."

Particularly, if the meningitis is basilar or universal or even covering a large brain area. The mere matter of tearing off a few inches of cortex with the adhesions might have some attention. Certainty of a very circumscribed, easily accessible and small pachymeningitis offers chances for operating, but more study should previously be accorded the case than the rash operator indulges.

"8. Establishment of permanent drainage beneath the scalp is permissible in the beginning of a terminal dementia succeeding chronic hydrocephalus."

What earthly benefit can accrue from interfering with the brain, or even the scalp, of a terminal dement, when the hydrocephalus is compensatory, the cerebral lobes shrunken, *atrophied*, *sclerosed*, every vestige of hope of return of reason vanished as though the head were cut off? The fluid merely fills the space between the shrunken brain and the meninges.

"9. Operation for epileptic insanity is advisable whenever there are symptoms pointing to a focal lesion."

This could apply to any Jacksonian epilepsy of cortical origin. Such instances are one in a thousand among the insane and the brain disorganization is too advanced to make it a warrantable operation. Observe the extravasations, the leucocytic exudates that have organized at the brain base, the universal heavy dense membranes and adhesions found in epileptic insane autopsies, and then, even with a focal lesion, which is not the only brain trouble, what hope is there from an operation?

"10. Experimental trephining in the early stage of general paralysis of the insane is considered worthy of further trial."

Every such experiment has been a wretched failure, beside too many cases of general paralysis of the insane (paretic dementia) have been improperly diagnosed as such. An alienist would feel like throttling an operator who cut into the skull of a maniac, whose chances of recovery are excellent, through mistaking his case for one of paretic dementia, which has been repeatedly done.

"11. Operation should be done for even a suspicion of the existence of a gummy deposit in the bone or meninges."

If gummata are in one area they are probably in another; a favorite site is about the pons and in the course of the sixth pair of nerves. The removal of a single gumma or group of gummas from one part does not check the disease. A vigorous saturation with K. I. would be all that is primarily warranted and particularly where only a "suspicion" of a gumma existed.

"12. The formation of fenestræ in the skull is permissible whenever there is evidence of intracranial pressure, even of unknown origin. "Sometimes cerebral pressure is from constipation. We have such articles as cathartics, ergot, iodid of potassium, and a neurologist might hit upon some other means of relieving intracranial pressure, if the term intracranial is meant in the sense in which we use the word intrauterine. In another intracranial meaning an exostosis, or what is sometimes improperly called an endostosis, may produce brain pressure and the fenestra might help, or it might afford an opportunity for hernia cerebri, which is scarcely desirable."

There is something in Lannelongue's craniotomy (not craniectomy) in cases of primary synostosis to allow the brain room to expand, and if surgeons would allow the alienist to select cases of idiocy and imbecility suitable for operation, instead of rushing into craniotomy with the average surgical unfamiliarity with the insanity, the percentage of successful results would undoubtedly rise. Where the brain has undergone permanent retrogradation, and of this the alienist is the best judge, there can be no hope from any treatment.

Imagine the resentment of the surgeon were some neurologist to venture advice in a case of intestinal resection, but the alienist has as good a right to feel insulted when a surgeon, who has but the most superficial ideas of psychiatry, promptly takes up his knife and trephine and proceeds to "cure" incurable dements, imbeciles, and other comparatively brainless unfortunates, without seeking advice from those who make such matters a life study. There are vast experimental fields left over from the last century in clitoridectomy, circumcision, rectus muscle snipping for insanity, in spite of the failure of the great Chicago "orificialist" with his sphincter cut-

ting for mental and all other troubles, including baldness and corns, and notwithstanding the controversy between the State Board of Charities and another "orificialist" who castrated a lunatic now in the Elgin Hospital for the Insane.

Castration, oöphorectomy, sphincter, and ocular rectus muscle cutting, clitoridectomy and other reflex pleasantries, can earn fees at less risk to the patient, just as well as brain surgery with inferior knowledge of psychiatry and cerebral pathology, even when performed by a "brilliant operator."

70 State Street.

THE AURAL MASSEUR IN THE MANHATTAN EYE AND EAR HOSPITAL.

BY CHEVALIER JACKSON, M.D.
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The aural masseur described by me in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION of May 11, 1895, had given me such good results in the treatment of defective hearing and tinnitus aurium, in cases of otitis media catarrhalis chronica, that I sent an instrument like my own, some six months ago to Dr. D. B. St. John Roosa for a thorough trial and opinion on its merits. He placed the instrument in the Manhattan Eye and Ear Hospital, where it was tested thoroughly in charge of Dr. Bretano Clemens who has sent me the following report:

I submit to you some results of my observations of the use of your electro-pneumatic masseur in cases of tinnitus aurium. Of late years so many instruments have been brought to the notice of the profession for the relief of this distressing affliction, and the advantages of each have been so strongly maintained by their various supporters, that I undertook the task of ascertaining the special field of usefulness of your masseur with some prejudice against it. The relief obtained in a number of cases in which other known methods and remedies had failed, however, has convinced me of the merits of the instrument, and of the correctness of the principle upon which it is founded. My tests of it have been made in all classes of cases of non-suppurative ear disease associated with tinnitus aurium, viz., otitis media catarrhalis chronica, including, the hypertrophic and the atrophic forms; disease of the auditory nerve, and in the mixed form where the sound-conducting and sound-perceiving apparatus are simultaneously involved. It will be seen from the details hereafter given, that some cases were more promptly benefited than others, and that in a few, the tinnitus was so much intensified that further use of the method was out of the question.

In applying the instrument, I was particularly cautious *not* to depend upon a patient's statement that the machine was "working," but by substituting the pneumatic speculum of Sieglé for the ear tip you sent with the masseur, I could distinctly observe the movements of the membrana tympani and malleus to my entire satisfaction.

The usual hyperemic conditions observed after using the Delstanche masseur, I have never witnessed after an application of your instrument.

Premising, that upon the whole, the use of your instrument has demonstrated its value to my mind, the following are the details of a few cases which I have been able to observe, and which will serve to facilitate the further study of its application:

Case 1.—Male, physician, aged 55. Applied for relief of tinnitus on Feb. 5, 1895. History: distressingly loud tinnitus, like escaping steam, and distressed for past ten years; occasional attacks of vertigo which are slight; plethoric, and unsteady in walking. Objective examination: both membranes very opaque, some retraction and hyperemia along the malleus handle.

Tests: watch R., 0-60; L. 0-60; whispered voice R. 0. L. 0; no improvement after inflation. Absolutely no bone conduction for forks C1, C2, C3 and C4. C fork was perceived only for an instant. Slight aerial conduction of low tones only.

This patient had been treated by many famous otologists of this country, but derived no benefit from their efforts. Removal of the ossicles was advised several times, but absolutely refused. The masseur was used with no effect for several weeks, applications being made tri-weekly, but on March 15 he reported with much glee that the noise had suddenly left him the night before for the first time in many years, and remained away for twenty-four hours. He is much improved; the noises though present, are not distressingly loud. This treatment was continued for several weeks longer, and he then departed for Augustine, Fla., much better and freer from tinnitus than ever before.

Six cases similar to the one quoted have been much benefited, the tinnitus becoming intermittent or remaining continuous with less intensity.

Case 2.—O. M. C. C. Female, aged 22, general housework, applied for relief of tinnitus aurium and deafness on Feb. 28, 1895. History: deafness principally in left ear, for past two years and rapidly growing worse. Tinnitus constant, and of pulsating variety, intensified by recumbent position. Deafness right ear for past two months—tinnitus ringing, not constant. Hears better in quiet place. Objective examination: right ear, membrana tympani cloudy, dull, and slightly retracted. Left ear, membrana tympani very much retracted, so that the malleus handle is nearly horizontal; cloudy, slightly hyperemic. Sieglé shows malleus to be rigid. Nose: rhinitis hypertrophica chronica. Luschka tonsil slightly enlarged. Eustachian tubes closed.

Tests: watch R., 5-60 after catherization 12-60; L., c-60, after catherization, 3-60. Right ear, C, 23-21; C1, 18-10; C2, 28-20; C3, 18-10; C4, 25-12. Left ear, C, 8-25; C1, 8-12; C2, 15-25; C3, 13-10; C4, 15-10.

Treatment; Eustachian catheter and menthol vapor. The pneumatic masseur was used, but each application increased the intensity of the tinnitus in the left ear, to such an extent that further use of it had to be discontinued.

In another case, exactly similar to the one first quoted, the result was equally unfavorable after using the masseur. Therefore, in twenty-two cases of otitis media catarrhalis chronica, associated with tinnitus aurium and treated with your masseur, two cases were unfavorably influenced, and twenty more or less benefited.

The following brief report will show how quickly relief follows the application of the masseur in some cases of O. M. C. C.:

Case 3.—Female, aged 35, servant; came to the hospital on Jan. 15, 1895 for treatment. History: deafness followed an attack of scarlet fever fifteen years ago, and is gradually growing worse. Tinnitus aurium in right ear. Hears better in noisy place. Objective examination: right membrana tympani moderately retracted, cloudy. In left ear the local appearances are similar.

Watch R., ½-60: L.c.-60. No improvement after inflation. Whispered voice, right, three inches; left whispered voice, six inches. Forks: right C, 0-33; C1, 5-11; C2, 14-23; C3, 8-12; C4, 10-8. Left C, 15-33; C1, 7-12; C2, 16-21; C3, 12-12; C4, 15-8. Vertex test heard better in left ear.

Treatment: the electro-pneumatic masseur relieved the tinnitus at once. After three applications the noises disappeared, and have not returned up to the present time. The deafness remained uninfluenced.

MIXED CASES.

Case 1.—Female, aged 46; first came to hospital April 19, 1894, for treatment. History: deafness for past fifteen years, gradually increasing; hears better in a quiet place; considerable tinnitus aurium in both ears, which is always much increased during an attack of acute rhinitis. Objective examination: both membranes much thickened, slightly hyperemic and moderately retracted.

Watch R, 0-60, slight increase after catherization. Left 0-60, after politzeration, 0-60. Whispered voice R. E., three inches. Whispered voice L. E., two inches. Vertex test (Weber) heard better in right ear. Forks: right, C, 14-11; C1, 10-4; C2, 26-0; C3, 8-0: C4, 6-0. Left, C, 13-8; C1, 7-4; C2, 25-0; C3, 7-0; C4, 8-0.

Nose: rhinitis hypertrophica chronica. Tubes closed.

Treatment: the Eustachian catheter, menthol vapor, and an occasional passage of an Eustachian bougie, with the use of the Delstanche masseur, which was employed for six or seven months, with but indifferent results.

Three months' use of your pneumatic masseur gave only transient relief from the noises. On March 21, 1895, the tinnitus was louder than ever before since being under treatment. She had taken fresh cold. On April 4, 1895, she reported considerable improvement, and on the 13th, that the tinnitus disappeared from right ear entirely, it remaining in the left, but very feebly. Tuning fork tests were made on April 13 with following result:

Right, C, 7-10; C2, 10-0; C4, 8-0; Left, C, 8-11; C2, 0-0; C4, 8-0. Watch, right, 1-60. Left, 0-60. Right, whispered voice, eight inches; left, ten inches. The masseur treatment will be continued.

Case 2.—Female, aged 40, housekeeper, first came to hospital for treatment Jan. 22, 1895. History: afflicted with deafness and tinnitus for many (?) years. Three weeks ago took a heavy cold, and has been growing rapidly worse. Tinnitus principally left, constant and whistling. Objective examination: membrana retracted and very cloudy. Siegle demonstrated no ankylosis of hammer. Chronic follicular pharyngitis, tubes closed.

Tests: left ear, watch 0-60, after catherization 0-60. Whispered voice two feet, after catherization two feet. Vertex test (Weber) heard equally well in both ears. Fork test: left C, 12-15; C1, 10-5; C2, 10-3; C3, 8-4; C4,12-4. Treatment: electro-pneumatic masseur and Eustachian catheter. Two days later reports that the tinnitus is exactly the same; the masseur only gave relief for eight or ten hours. Four days later, much improved, the tinnitus remaining away for a longer period after each application.

This case gradually improved and finally ceased attending the clinic. Ten cases corresponding to those quoted were treated with varying results. Some were promptly benefited, while others only experienced amelioration from the existing tinnitus.

A. The electro-pneumatic masseur affords relief to many patients suffering with tinnitus aurium. How permanent this relief may be, must be determined by more extended observation.

B. The use of the instrument is apparently contra-indicated in cases where the existing retraction of the membrana tympani and malleus causes an increased intra-labyrinthine pressure.

CIVIL SERVICE REFORM IN STATE INSTITUTIONS—REORGANIZATION OF THE MEDICAL STAFF.

BY BOERNE BETTMAN, M.D.

PROFESSOR OF OPHTHALMOLOGY AND CLINICAL OTOLOGY IN THE COLLEGE OF PHYSICIANS AND SURGEONS; PROFESSOR OF OPHTHALMOLOGY IN THE POST-GRADUATE MEDICAL SCHOOL; PRESIDENT OF THE ILLINOIS STATE BOARD OF CHARITIES. CHICAGO.

All measures toward reform in the treatment of the insane will prove an utter failure until the manner of appointing the medical staff is radically changed.

The superintendent and head of the institution must possess not only the requisite medical skill to fit him for the care and supervision of the patients intrusted to him, but he must also be endowed with executive abilities to maintain a business-like organization and to exact well-disciplined service from a large *personnel*. Burdened as he is by multitudinous duties, he naturally is obliged to delegate the treatment to the medical assistants. To them is intrusted the diagnosis of the mental complaint and its subsequent treatment. Upon them rest great responsibilities.

Medical assistants are ordinarily appointed through political or other influences. The superintendent is often not consulted in the matter, but is forced to submit to the dictates of others, whose only concern it is to obtain a job for some influential friend. Persons absolutely unfit, both by education and character, are thus thrust upon the institution, to the detriment of its insane inmates.

The number of physicians in our State asylums is inadequate; one for every four or five hundred patients. It is commonly acknowledged that one medical man should take care of no more than two hundred. Routine and careless treatment is thus avoided. The individuality of each case can be more readily studied. The now over-burdened physician has but little time at his disposal for further improvement and recreation.

The isolated position of the asylums is another source of danger to the medical mind. Far distant from medical centers, cut off from associations with scientific men, deprived in this matter of the stimulus necessary to further improvement and original research, his ardor is either allowed to lie dormant or absolutely to die out for want of encouragement.

A laboratory well equipped exists in but one of our State asylums. Its value can not be over-estimated. It is a necessary adjunct. The practical results obtained in medicine are the outcome of the applications of scientific research and investigations. The latest improvements in surgery were only possible after the untiring labors of a Pasteur and Koch. The cure for diphtheria and hydrophobia depended upon the cultivation of bacteriology. Practitioners have neither the time nor the special qualifications to devote to strictly scientific pursuits. A specialist is necessary. A pathologist well trained and endowed with the proper zeal is needed for this work. His presence will also have a stimulative effect on the medical staff. If ambitious, he will imbue others with such a spirit for earnest and conscientious work that enthusiasm will be awakened. No individual can perform labor creditably unless he is devoted to his vocation. This is especially true in the calling of a physician. Constant and untiring research is an especial feature of his life. Science is ever making such rapid strides that to keep abreast of the times requires uninterrupted study.

To remain at a standstill means stagnation, deterioration. The introduction of staff meetings, for the purposes of consultation and discussion of medical themes and analysis of cases, will also call into life, taste for more thorough examinations of and conscientious devotion to the patients. These various reasons induced the State Board of Charities to issue a circular letter to the trustees of the four State asylums requesting them, in order to improve upon the present methods, to appoint for each hospital a pathologist and a number of internes.

General hospitals the world over, have for years given recent graduates of medicine an opportunity to

get a practical knowledge of their profession by employing them as assistants to the medical staff. Residing as they do in the hospital, and being called upon to perform certain services to the sick, under the supervision of the physician in charge, they obtain ample opportunities of acquiring useful knowledge and of profiting by the experience of their older and better informed superiors. The patients, on the other hand, have constantly at hand well educated assistants who are intelligently carrying out whatever orders may be given by the attending surgeons. This system of internes is doubly beneficial. Again, a certain amount of routine clerical work, as writing up the history of the patients, keeping daily record of their condition, etc., is performed by the interne, and relieves the attending physician of useless and unimportant labor, giving him time for more important work and self-improvement.

The appointment of internes must be absolutely free from prejudice and preferment of all kinds. The ablest only are worthy of these positions, for they alone are capable of profiting by the advantages allotted to them. They only possess the qualifications which will insure earnest effort and arouse a desire for progress. These competitive examinations should be free to all senior medical students of medical schools in the State of Illinois and to all Illinois practitioners of not more than five years' standing. Those senior students who succeed in obtaining sufficiently high marks to become internes should only then be accepted as such, after having received their doctor degree from their respective colleges. The closing of the college year varies in different institutions. To induce a sufficiently large number of students to compete, before returning to their homes, the examinations should be held before May, and the successful candidates be assigned to their duties a few months later, after the final college examinations have taken place. All efforts should be made to place the examinations on a strictly impartial footing. The internes should receive beside their board and lodgings, a small monthly salary. They should be expected to serve at least one year, and be permitted to fill vacancies occurring in the staff of assistants. This system, if rigidly enforced, will be one step toward the introduction of a system of civil service reform in the medical corps of our institutions, which can only be associated with the highest benefit to all parties concerned. It will secure for the State a perfect medical service, and for the ambitious student untold opportunities for acquiring scientific and practical attainments.

A year ago the State Board of Charities sent a circular letter embodying the above views to the trustees of the four State lunatic asylums, and requested also a conference of the superintendents and the President of the State Board. At this meeting, the subject was thoroughly discussed and the result was the appointment of a board of examiners to conduct a competitive examination on a truly impartial basis. This board consisted of the following gentlemen, who were to prepare questions in their respective branches:

Dr. R. Dewey—Mental Diseases.
Dr. J. H. Etheridge—Gynecology.
Dr. Adolph Meyer—Anatomy and Physiology of the Nervous System.
Dr. Louis McArthur—Surgery.
Dr. Hugh Patrick—Nervous Diseases.
Dr. William E. Quine—Medicine.

This board appointed at its first meeting,
Dr. Boerne Bettman—President.
Dr. Hugh Patrick—Secretary.

The board prepared the following circular letter, a copy of which was sent to every medical college in the State in good standing with the State Board of Health:

CHICAGO, April 5, 1895.

Notice is hereby given that a competitive examination will be held at Cook County Hospital, April 15, 1895, from 9 to 4 o'clock, for the appointment of internes to serve for a term of one year in the State Hospitals of the Insane, to be appointed as follows:

Northern Illinois Hospital for Insane, three internes (Elgin).

Eastern Illinois Hospital for Insane, four internes (Kankakee).

Central Illinois Hospital for Insane, three internes (Jacksonville).

Southern Hospital for Insane, two internes (Anna).

All senior students of, and all practitioners graduated within five years, from medical colleges recognized by the Illinois State Board of Health shall be eligible for this examination.

Candidates shall be examined in the following branches, viz.: practice of medicine, surgery, gynecology, mental diseases, nervous diseases, anatomy and physiology of the nervous system.

Each interne before entering upon his duties shall have complied with the legal requirements governing the practice of medicine in the State of Illinois.

Beside board and lodging, internes shall receive a monetary compensation not to exceed $20 per month.

Applicants will oblige the Board by immediately sending their names to Dr. Hugh T. Patrick, 34 Washington Street, Chicago.

By order of the Board of Examiners.

BOERNE BETTMAN, M.D., President,
HUGH T. PATRICK, M.D., Secretary.

Owing to unfortunate obstacles placed in the way of the Examining Board, the above announcement was not made until a late date, less than a week before the date of examination. Notwithstanding the short preparatory notice, nineteen applicants reported to the Secretary. Seven of these withdrew at the last moment, partly on account of a rumor which crept into the newspapers that internes were to be utilized as nurses. Six of the twelve aspirants obtained an average of 75 per cent. or more. One of these succeeded in obtaining a position in the Cook County Hospital. The remaining five drew lots, which resulted in two being assigned to Kankakee, one to Elgin, one to Jacksonville and one to Anna.

The seventh and eighth highest in rank having obtained an average of 70 per cent. were appointed first and second alternates. The examination was absolutely fair; the identity of the applicants was lost, by withholding from their papers, names and any sign or symbol which might disclose them. A card bearing the name and given number of each candidate was placed in a sealed envelope, which was only opened after the papers were examined and the winning number had been decided upon. This examination marks an epoch in the history of State medicine. Although the City of Chicago has but recently adopted at the polls, by an overwhelming majority, civil service reform, to the medical fraternity belongs the credit of having first conceived the plan and carried it into execution. The fundamental principle of all good government should be, "to the worthy belong the deserts," in contra-distinction to the war cry of political parties, "to the victor belongs the spoils."

As our superintendents are medical men, they

naturally will do all in their power to protect from harm the seed which has been planted, so it may sprout and develop into a sturdy plant, which will bear rich and bountiful fruit.

SOCIETY PROCEEDINGS.

Association of American Medical Colleges.

Sixth Annual Meeting, held at the Club House of the Hotel Rennert, Baltimore.

DR. E. FLETCHER INGALS, President, in the chair.

The minutes of the last meeting were read and approved, upon amendment, changing the records to indicate the presence of the representatives of the University of California and the Western Pennsylvania Medical College of Pittsburg, Pa.

DR. MICHAEL raised a point denying the legality or regularity of any action taken at San Francisco at the last meeting, as only twenty-three colleges were represented out of a total enrollment of forty-one colleges. The point was discussed by Drs. Millard, Cole, Street, King, White, Roberts, Thomas and Graham. The chair ruled this point as not well taken and that a legal meeting was held.

Roll call indicated the following named colleges represented by delegate, and were reported to the Secretary as being the official list of the present membership as called for under the amended Constitution and By-Laws. [To be published later.]

The Secretary submitted his annual report, which was adopted.

DR. N. S. DAVIS presided during the reading of the President's Address. [To be published later.]

Upon motion of DR. COLE, the address was adopted and ordered printed and also ordered circulated to all teachers of medicine in the country.

Upon motion of Dr. Millard, the President appointed a committee consisting of Drs. Osler, Baker and Graham to submit the names of distinguished teachers for honorary membership. The committee reported the following named persons: H. P. Bowditch, Harvard; Geo. H. Sternberg, Surg.-Gen. U. S. Army; J. M. DaCosta, University of Pennsylvania; N. S. Davis, Chicago Medical College; Levi Cooper Lane, Cooper Medical; Hunter McGuire, University Medical College; T. Gaillard Thomas, Columbia College. The report was adopted and the names reported elected to honorary membership.

The Secretary submitted the report of the committee on syllabus, and minimum of requirements, and upon request of the committee the sub-committee, consisting of Drs. Millard, H. A. Kelly and Bayard Holmes, were directed to make the necessary amendments and to print the same in the proceedings of the fiscal year.

The Constitution was by a unanimous vote amended, to provide that the annual meetings begin Monday, A.M., of the week in which is held the meeting of the AMERICAN MEDICAL ASSOCIATION.

DR. HOLMES presented a paper upon Libraries for Medical Schools, which was read and ordered printed.

The following notice of amendment to the Constitution was previously submitted by the Dean of the College of Physicians and Surgeons of Baltimore, to-wit: that Sec. 4, of Art. III of the Constitution be amended to read as follows: "Candidates for the degree of Doctor of Medicine in 1904 and thereafter, shall have pursued the study of medicine for a period of four years, and attended at least four courses of lectures of not less than six months' duration each," was read and discussed by Drs. Michaels, Holmes, Millard, Cranmer of Omaha, Friedenwald, Culbertson, Davis and Cole. Upon vote, the amendment was defeated by a vote of 30 nays to 5 ayes.

Upon motion, the action taken at California relating to the curriculum of study was confirmed.

The Judicial Council through its Chairman, Dr. Dudley S. Reynolds, reported as follows: in the matter of complaints against the College of Physicians and Surgeons of St. Louis the Council reported the methods, as disclosed, in bad taste and not in accord with the rules of the College Association. In the matter of the reference of the Ft. Wayne Medical College, regarding the matriculation of students, the action of the school was sustained.

In the matter of the communication of Dr. J. A. Larrabee of the Hospital Medical College, relating to the action of the Association in expelling the Kentucky School of Medicine from membership in this body, the Council reported that it had no opinion to express.

In the matter of the communication of Thos. H. Hoover, Regent of the Starling Medical College, the Council reported lack of definite information.

The rules submitted by the Judicial Council were adopted.

Upon motion of Dr. Larrabee, the colleges connected with the Southern Association of Medical Colleges were invited to make application for membership in this body.

In the matter of the application of the College of Physicians and Surgeons of Boston, and the Woman's Medical College of the Presbyterian Church of Cincinnati, the question of admission to membership was referred to the Judicial Council with power to act.

DR. J. A. LARRABEE moved that the disability of the Kentucky School of Medicine be removed, and it be permitted to apply for membership. The motion was seconded by the Secretary and adopted.

In response to a unanimous expression of the Association, the following named colleges were elected to renewed membership: the University of Louisville, the Louisville Medical College, the Kentucky School of Medicine.

The following officers were elected for the ensuing year: President, Wm. Osler; First Vice-President, J. M. Bodine; Second Vice-President, W. Graham; Secretary and Treasurer, Bayard Holmes. Judicial Council, Reynolds, Pancoast and Vaughan.

DR. COLE of the University of Colorado, submitted the following notice of proposed amendment to the Constitution and By-Laws, to wit: that Sec. 4, Art. III, be amended to read: "That the preliminary examination provided for, shall be conducted by a Board of Examiners in no wise connected with a teaching body of a medical college."

Upon motion, adjourned.

PERRY H. MILLARD, Secretary.

PRELIMINARY REPORT OF THE COMMITTEE OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON SYLLABUS OF A FOUR YEARS' COURSE OF MEDICAL INSTRUCTION.

In presenting this preliminary report your committee appointed at Baltimore, May 5, finds itself facing a problem requiring much time and study, and an emergency in the evolution of medical education calling for great promptness. Many schools are passing from a three year, and largely ungraded course, to a four year graded course. The traditions of the past must be violated and no authority or precedent for the new order is at hand.

Your committee wishes, therefore, to place before the colleges all the information in its possession, taking a very broad and liberal view of its duties. The reports of the sub-committees are given almost always in full. In a few cases it has been necessary to cut them down. The committee is unable to coördinate and simplify the syllabi, and recommend a complete syllabus of the full course at this time. It is possible that such a syllabus might be looked upon as interfering in a measure with the freedom of the teachers, even though it would be advisory only.

It is far from the intention of the Association to interfere in any way with the complete liberty of schools or teachers in the presentation of medical teaching, or crystallize upon them a course of study which would prevent or delay further progress.

So many teachers and so many colleges are calling for help in re-organizing their courses of study, that this incomplete report is offered with the hope that at the next annual meeting of the Association a complete and final syllabus may be handed in. Criticism and correspondence is solicited.

Before making a syllabus of the minimum required course of study for the guidance of members of this Association, it seems necessary to establish some unit of measure. The most common unit now in use among educators is, perhaps, the sixty recitation hour unit; or a recitation of one hour each day, five days in the week for twelve weeks, that is for three months. This unit of sixty recitation hours will be used in this report.

The following questions naturally present themselves and the discussion shows the present opinions of the committee:

1. How much work should be required of the student each year?

The student can reasonably be expected to work ten hours a day. Every recitation or lecture hour should require one and one-half hours of preparation. Four recitation hours would make the student's working day ten hours long. In medical schools the students are old enough and mature enough to stand this amount of work. Four recitation hours

would be equal to 9⅓ units of 60 recitations each for the minimum year of seven months. The four years would give a total of 37½ such units.

2. How can laboratory work and clinics be measured?

Much of the work in the medical colleges is either laboratory or clinical work. Neither of these requires much time for preparation, outside the time consumed in the laboratory or clinical amphitheater. Laboratory or clinical work may be reasonably counted as half time. Two laboratory hours or two clinic hours equal one recitation hour.

3. What should be the proportion of lectures or recitations, of laboratory work and of clinical work?

The committee is of opinion that the proportion of lectures or recitations is now in most American institutions much too large. For the present, we recommend that the work of the four years be nearly equally divided into three portions: one-third being given by means of lectures and recitations, one-third by laboratory methods and one-third as clinical teaching.

4. Shall all of this minimum of 37½ units be required, or may some of it be elective?

We believe that the larger portion of this minimum should be definitely laid out and required of every student by his college, but we urge that each college have a group of courses measured the same as other work which students may elect to fill out the full complement of courses required.

5. Is any particular order in the curriculum necessary or desirable?

Certain branches are necessarily primary, others are necessarily final. Anatomy is, for example, a primary study, and with physiology, embryology and bacteriology it should come before pathology. Pathology should be followed by general medicine and surgery, and these by the specialties. While no definite order is necessary, a certain natural sequence should be observed, so that the student may be led from the known to the unknown, from the concrete to the abstract, and from the special to the general. In this connection the sub-committees present many valuable ideas and suggestions.

Signed, HOWARD KELLY,
BAYARD HOLMES.

DR. N. S. DAVIS JR., gave a report on

MINIMUM OF REQUIREMENTS.

First Year—Lectures and Recitations—Hours per week.—Anatomy four, physiology four, histology and embryology two, chemistry three; *laboratory exercises*, physiology two exercises a week, chemistry three exercises a week, histology and embryology three exercises a week, bacteriology three exercises a week. Dissections. [120 hours].

[In a nine months course this would equal about 15 units].

Second Year.—Anatomy two, surgical anatomy and operations two lectures and recitations, practical exercises [60 hours], general pathology three lectures and recitations, pathologic laboratory three exercises, physiologic laboratory three exercises, physical diagnosis two lectures and recitations, materia medica two lectures and recitations. Dissections [120 hours].

[In a nine months course this would equal about 11 units].

Third Year.—Practice two lectures and recitations, surgery two lectures, obstetrics three lectures, therapeutics three lectures, hygiene one lecture, pædology one lecture, dermatology one lecture.

Clinical instruction: medicine three hours, surgery three hours, gynecology one hour, eye and ear one hour, pædology two hours, dermatology two hours, mental and nervous one hour.

[In a nine months' course this would equal about 10 units.]

Fourth Year.—Practice two lectures and recitations, surgery two lectures, orthopedia one lecture, gynecology two lectures, mental and nervous one lecture, eye and ear one lecture, jurisprudence one lecture and recitation half year, laryngology one lecture and recitation half year.

Clinical instruction: medicine three hours, surgery three hours, gynecology one hour, eye and ear one hour, pædology two hours, dermatology one hour, mental and nervous one hour, orthopedics one hour, laryngology one hour.

[In a nine months course this would equal about 10½ units.]

By laboratory exercises, is meant exercises not to exceed two hours in length. The arrangement by years is capable of deviation. The time allotted to some of the topics may with advantage be increased. The clinical exercises may likewise be extended to advantage. Each student should be furnished an instrument or microscope for laboratory use. In the chemic laboratory each student should have his own desk and apparatus. Ample equipment of all laboratories should be insisted upon.

SCHEDULE OF MINIMUM OF REQUIREMENTS.

This represents the minimum amount of work in each branch entitling colleges to remain in active membership in this Association. See report of 1894.

Represented in hours "D," indicates lectures or recitation exercises. "L," indicates laboratory work.

Histology and embryology, D, 50, L, 700; anatomy, D, 100, freshmen; D, 100, juniors; laboratory, 100; dissection of entire body.

Physiology, D, 100, L, 75; chemistry, D, 125, L, 125; bacteriology, D, 25, L, 150; hygiene, D, 25; medical jurisprudence, D, 12; practice, D, 200, weekly clinical instruction; surgery, D, 200, weekly clinical instruction; surgical anatomy, D, 100, including laboratory work: obstetrics, D, 150, including recitations; ophthalmology and otology, D, 25; mental and nervous, D, 25; materia medica and therapeutics, D, 125; dermatology, D, 25; orthopedia, D, 25: genito-urinary, D 25; pædology, D, 25; physical diagnosis, D, 75; pathology, D, 50, L, 100; laryngology, D, 25.

DR. BAYARD HOLMES, of Chicago, presented a report on

AN IDEAL WORKING FOUR-YEAR MEDICAL COURSE, LEADING TO THE DEGREES A. B. AND M.D.

Prepared for a university having regular and homeopathic medical teaching. A major equals one of the 60 hour units used above.

Admission to this course is granted only to those who have completed the sophomore year at this [any] university and to those who pass an examination on the required work, as laid down in the university calendar.

The University College embraces thirty courses of sixty recitation hours each. This college requires two years of work. When these thirty courses are completed, the student will receive A. B. at the succeeding Commencement. The *required* courses of the University College are as follows:

(*a*). Chemistry, organic, toxicology, 2 majors.
(*b*). Medical botany and pharmacognosy, 1 major.
(*c*). Pharmacy, 1 major.
(*d*). Biology, 1, Huxley and Martin, elementary biology. Martin and Mole, I, II, III, 3 majors—2, bacteriology, 1 major.
(*e*). Histology of a mammal, histologic technique, 3 majors.
(*f*). Embryology, 2 majors.
(*g*). German, 2 majors.
(*h*). Medical bibliography and methods of research, ½ major.
(*i*). Experimental or laboratory physiology, including experimental psychology, 6 majors.
(*j*). Human anatomy, 4 majors—dissections, 1 major.

Students who already have any part of this course may elect under the direction of the Dean, such accessory branches as are necessary to complete the required amount of work.

The Professional College embraces thirty majors in medicine, with a wide margin of electives. This college requires two years work. The required courses are the following:

(*a*). Pathology, 3 majors.
(*b*). Medicine, 3 majors.
(*c*). Surgery, 3 majors.
(*d*). Obstetrics, 2 majors.
(*e*). Elementary State Medicine, 2 majors.
(*f*). Elective in specialties, 6 majors.

The eleven electives must be taken with the advice and consent of the Dean, and they must be properly proportioned among clinics, lectures, researches, and theses offered every year. The elective work should be laid out as occasion requires. The following is only suggestive:

Ophthalmology, 1 major.
" second, 1 major.
Otology, 1 major.
" second, 1 major.
Laryngology, 1 major.
" second, 1 major.
Male genito-urinary surgery, 1 major.
Homeopathic materia medica, 1 major.
" therapeutics, 1 major.
" practice of medicine, 2 majors.
Dental surgery, 2 majors.
" 3 majors.
Gynecology, 1 major.
" second, 2 majors.
Orthopedic surgery, 1 major.
" second, 1 major.
Medical jurisprudence, 1 major.

Study and research in medical laws of the United States, (thesis work), 1 major.

Vital statistics, 1 major.

Elements in the fluctuation of vital statistic research, (thesis work), 1 major.

Laws relating to hospitals in the United States, research, (thesis work), 1 major.

State Boards of Health, study of results, origin, laws and evolution research, (thesis work) 1 major.

The development of the child to manhood. The normal child. The abnormal factory child, research, (thesis work), 1 major.

Blindness, history, etiology, education of blind in United States, expense, possible reduction of expense, methods. (Thesis work), 1 major.

The defectives of the United States. Origin, cost and possible limitation. (Thesis work), 1 major.

The Health Officer, his duty and privileges. (Lectures), 1 major.

Life insurance examinations. The duties of the physician and the company, 1 major.

The railway and corporation surgeon. His duties, privileges and his emergencies. (Lectures), 1 major.

Child labor. Lectures and class research. Semmarium, 1 major.

These courses may be multiplied, as the resources of the institution increase. The same degree should be given to all medical students, on the same amount of work.

The seminar and theses courses require much original work and are conducted by a teacher with a small class. Two hours, one meeting a week equals five recitation hours, and a major is therefore completed at the end of three months.

The following circular was sent out to guide the sub-committees in their work·

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES.

Circular of Information to Sub-committees on Syllabus of Studies.

Gentlemen:—At a regular annual meeting of the Association of American Medical Colleges held in San Francisco, Cal., in June, 1894, the Constitution of the Association was changed, providing that hereafter candidates for the degree of M.D. be required to have completed attendance upon at least four courses of lectures before receiving a degree. Beginning with this year, the course of study is therefore extended to four years, with attendance upon at least four courses of lectures, of not less than six months duration, in different years.

The action of the Association upon this most important move was substantially unanimous.

There was likewise appointed at this session, a General Committee on "Minimum of Requirements" and "Syllabus of Lectures." The committee consists of the following named persons, to-wit: Professors P. S. Conner, of Cincinnati, Ohio; C. B. Stemen, of Fort Wayne, Ind.; Victor C. Vaughan, of Ann Arbor, Mich.; Wm. E. Quine, N. S. Davis Jr., and E. Fletcher Ingals, of Chicago, Ill., and Perry H. Millard, of St. Paul, Minn.

It is the purpose of this committee to aid in bringing about greater uniformity in the methods of admission of students to the study of medicine, in the admission of students to advanced standing with credits from other colleges, in the classification of students and in methods of instruction.

The General Committee held its first meeting in Chicago, Nov. 30, 1894. It was deemed advisable to act with deliberation and seek the advice and coöperation of some of the leading educators of the country in the preparation of a syllabus, and to divide the work of its preparation into a number of sub-committees, corresponding in number to the number of different chairs to be represented in the proposed four years' course.

By resolution of the General Committee, the different chairmen are at liberty to enlarge the number of their committee, or to perform their work without assistance. The following named persons were selected to serve as Chairmen of the different sub-committees, to-wit:

History and Embryology, T. Mitchell Pruden, New York.
Anatomy, Thomas Dwight, Boston.
Physiology, Henry P. Bowditch, Boston.
Chemistry, Walter S. Haines, Chicago.
Bacteriology, Roswell Park, Buffalo.
Hygiene, Victor C. Vaughan, Ann Arbor.
Medical Jurisprudence, B. S. Folsom, Boston.
Materia Medica and Therapeutics, H. C. Wood, Philadelphia.
Practice, Wm. Osler, Baltimore.
Gynecology, Howard A. Kelly, Baltimore.
Surgery, P. S. Conner, Cincinnati.
Obstetrics, W. W. Jaggard, Chicago.
Pathology, Wm. Welch, Baltimore.
Mental and Nervous, Daniel R. Brower, Chicago.
Diagnosis of the Chest and Physical Diagnosis, E. Fletcher Ingals, Chicago.
Ophthalmology, E. L. Holmes, Chicago.
Otology, Henry Gradle, Chicago.
Pædology, T. M. Rotch, Boston.
Genito-Urinary, J. H. Dunn, Minneapolis.
Orthopedia, Virgil C. Gibney, New York.
Laryngology, James N. Mackenzie, Baltimore.
History of Medicine, N. S. Davis, Chicago.

The sub-committees are requested to report, covering the following points in particular:

1. In a four years' course of not less than eight months' duration each year, how much time do you suggest be devoted to your branch?

2. Of the whole number of hours recommended, how divide as to didactic, laboratory, recitation and clinical instruction?

3. At what time in a four years' course should the instruction in your branch be afforded?

4. Any suggestions of subjects to precede your branch before permitting the student to enter upon the same?

5. Is it wise to credit work done in other schools, or would you recommend that students be admitted to advanced standing, only after an individual examination in each branch, below the class the student may desire to enter?

6. Suggest a rule for the classification and grading of students suitable to a four years' graded course of instruction.

7. Prepare a detailed syllabus of the topics you deem suitable for instruction in your branch, and their manner of presentation to the student.

It is intended to combine the report of the several committees and issue the same as "A Syllabus for the Use of Teachers and Students of Medicine."

The members of the different committees are requested to submit their reports to the Secretary at St. Paul, Minn., not later than March 1, 1895. A joint meeting of the General and sub-committees will occur before the meeting of the Association, which took place in Baltimore in May of the present year. Respectfully submitted,

PERRY H. MILLARD, M.D.,
Secretary Association American Medical Colleges.

REPORT OF SUB-COMMITTEE ON MATERIA MEDICA.

In a four years' course of not less than eight months' duration each year, materia medica and therapeutics should receive attention during three of these years, viz., the second, third and fourth years. Instruction should be given as a graded course.

First Year. Introductory Work. Botany.—By beginning the study of materia medica the second year in the course, the student has an opportunity to receive instruction in botany and chemistry during the first year. Botanical knowledge should be insisted upon, and the necessary instruction for the acquirement of such knowledge should consist of at least thirty hours devoted to lectures or recitations with some additional time for laboratory work.

Second Year. Materia Medica.—During the second year, two hours weekly should be devoted to the study of materia medica, giving special attention to pharmacognosy and pharmacology. Such instruction should by preference be given in the laboratory and supplemented by recitations.

Third Year. Therapeutics.—Two hours weekly for the school year, should be given to therapeutics studied from the drug standpoint. Such instruction may be given by lectures. In this work, drugs may be studied individually, as represented by such writers as Waring and Ringer, or collectively as represented by the works of H. C. Wood, Bartholow, etc.

Fourth Year. Therapeutics.—Two hours weekly, for the school year, should be given to the subject of therapeutics studied from the standpoint of disease. Such instruction should be given by didactic and clinical lectures. The character of such work is well represented by Hare's "System of Practical Therapeutics." H. M. BRACKEN, M.D.,
Professor Materia Medica and Therapeutics,
University of Minnesota.

REPORT OF SUB-COMMITTEE ON ANATOMY.

[In conformity with your request of April 19, I make the inclosed suggestions regarding the character and order of

work to be done in anatomy, in a four years' course. This, as you note, does not include any work in histology and embryology. These studies should in most part be synchronous with the lectures in anatomy. The histology coming in the first year and the embryology in the second year. This course, as outlined, is practically what is being done in the college at the present time.—G. A. HENDRICKS.]

The greater portion of the student's work in anatomy is memorizing names and the forms of objects. Lectures do not give him much assistance. The individual must do this himself. He can, however, be materially aided in his work by pursuing it logically under the guidance of an instructor, by the use of the objects to be studied, and by the stimulation of frequent recitations.

Technical terms should be learned, as far as possible, in the first year. The feature of this year's work should be the study of specimens in the laboratory, supplemented by frequent recitations from the object. Lectures are of minor importance, and should be confined more to generalizations than to minute descriptions.

The dissection and study of muscles may be done in the first year, after the study of bones and joints, and following the lectures and demonstrations on myology.

The work of the second year should be so arranged that the description of the viscera should precede the advanced course in histology and embryology, and the lectures on the physiology of these organs.

Dissecting should be done in the second year, and should not begin until the lectures are so far advanced that the student follows the class-room demonstrations. In point, the student should not dissect to understand the lectures, but the lectures should explain and direct him in his practical work.

The instruction of the third year, unless it can be given in the laboratory, must be done by lectures.

Course of Study First Year.

Introduction: Principles of systematic zoölogy. Fundamental characteristics of vertebrates. Classifications of skeletons. Bones—classification. Bones—features; classification of. Typical vertebra, ten hours.

Etiology: Lectures and recitations, thirty hours. Laboratory work—sections, each section twenty-one afternoons, each week six hours, eight weeks forty-eight hours. One lecture per week. Two recitations per week.

Syndismology: Lectures and recitations twelve hours.

Myology: Lectures and recitations thirty hours.

Laboratory work. Two afternoons each week, six weeks, thirty-six hours. Two lectures per week. One recitation per week.

Attendance upon second year lectures covering thoracic, abdominal and pelvic viscera.

Second Year.

Organs of circulation, respiration, digestion, reproduction, genito-urinary, thirty hours.

Abdominal walls, regions, contents.

Hernia—inguinal, femoral, perineum.

Anatomy of scalp, face, neck. Anatomy of thorax, axilla, arm, forearm, etc. Anatomy of pelvis, thigh, leg, thirty hours.

Nervous system, cord, brain and membranes. Cranial nerves, spinal nerves. Sympathetic system, twelve hours.

Third Year.

Regional or surgical anatomy: Landmarks; surface markings. Review of descriptive anatomy by recitation. Surgical regions, demonstration of relations. Location and position of viscera. Advanced anatomy of brain and cord. Advanced anatomy of special sense organs.

BOSTON, MASS., March 19, 1895.

DR. P. H. MILLARD, *Dear Sir:*—I feel that I owe you an apology for never having answered your letter of two or three months ago. I consulted one of my colleagues as to what course to take. He gave me no opinion, and I forgot all about it. It is out of the question for me to give you, now, an elaborate or formal answer or to call a committee together; but owing to my previous neglect I can not do less than give you my personal and informal opinion.

The question, if I remember right, was as to what is the best arrangement of a course in anatomy in a four years' course?

This must vary with the school. The course here includes two years. In the first, is taught histology, embryology and descriptive anatomy. This, however, is taught more and more topographically from the very beginning.

In the second year, there is advanced anatomy and applied anatomy. Though it does not do so with us, this should include all surgical and surface anatomy.

Dissecting should certainly be carried on through a part of both years. It is not well to have it begin before the student knows the bones and joints. On the other hand, it should not be finished in the first year, as the student will appreciate it more in the second. Regretting that I can not give you a formal report, I am

Yours very truly, THOMAS DWIGHT.

Harvard University Medical School.

REPORT OF THE SUB-COMMITTEE ON CHEMISTRY.

For various reasons it does not appear advisable, at least for the present, to prescribe any rigid and definite rules for the course of instruction in chemistry in medical colleges. The science is one of such great breadth, and opinions among the best men in the department vary so widely as to exactly what subjects should be selected for study, and as to the best means of imparting instruction regarding them, that it seems better to allow a wide latitude for the individual choice of each teacher, prescribing only in a general way the work that should be required in colleges belonging to this Association. Your sub-committee, therefore, presents below its views regarding the minimum requirements of instruction in chemistry in medical colleges. No institution should give less than this, and it is to be hoped that all will give more. The subjects for instruction and the arrangement of the different courses are given only in brief outline, the details of the course being left to the judgment of the individual teacher.

One of the requirements for admission to the colleges belonging to this Association is a fair knowledge of the elements of physics, and this requirement should be insisted on most strenuously. There is not a department of medicine that does not need this knowledge for its intelligent study. This is especially true of chemistry, and with many colleges it is customary to precede the instruction in this branch by a short course in physics. This seems undesirable, as it takes valuable time from the study of chemistry, and, moreover, it is unnecessary if the requirements for admission are adhered to—physics having already been studied before entrance to the college is granted. If deemed advisable, a separate course of instruction in somewhat advanced physics might advantageously be given during the first year; but it would seem best to have this totally independent of the course in chemistry, so that the time assigned to the latter may not be at all abridged.

The study of chemistry, therefore, should begin with the commencement of the first year's course, and it should be continued during, at least, the first and second of the required four years in the medical college. The first year may be profitably devoted to inorganic chemistry, with perhaps an introduction to organic chemistry. The instruction should consist of lectures, recitations, and laboratory work. To the first and second not less than seventy-five hours should be given, and fully one-half of this time should be devoted to recitations. At least twenty-five laboratory exercises, of not less than two hours each, should be given to every student during this year.

In the second year, organic chemistry may be taken up, or if already begun in the first year, may be continued, and, following this, a course should be given in physiologic chemistry, when especial attention should be devoted to the urine, both in health and disease. During this year, also, instruction may advantageously be given in toxicology, unless that subject is taken up in connection with the different poisons as they are treated in the general course. At least seventy-five hours should be assigned during this year to the didactic consideration of these subjects, and not less than one-half of this time should be given to recitations. Fully twenty-five exercises of not less than two hours each should be devoted to laboratory work.

At fixed intervals during the entire course, written examinations may advantageously be given to test the progress of the class, and final examinations should be given at the end of each of the two years on the subjects taught therein.

The sub-committee would suggest that the subjects to which the most time is given, in both years, be those most intimately connected with medicine. Those elements and compounds should be particularly studied which are of use in the healing art, while those not employed in medicine, or of purely theoretical importance should be either omitted or very briefly discussed. Thus, iodin, mercury, alcohol and strychnin should be dwelt upon at length, while cobalt, zirconium, hexane, and the azo colors may be dismissed with a few words, if mentioned at all. The field of chemistry is so

exceedingly broad that unless some limitation of this kind is practiced, many subjects of the deepest interest in medicine must necessarily be omitted.

While, as before stated, practically all the work in chemistry may be completed in the first two years of the four years' course, yet it would seem highly advantageous to introduce a small amount of instruction in what might be called clinical chemistry into the last year. One exercise a week might be given to the work, chiefly perhaps in the laboratory, when the examination of urine, gastric juice, and other secretions, tests for the more important elements and compounds, and the incompatibility of drugs in prescriptions could be reviewed. This would afford an excellent means of reviving a knowledge of the more important parts of medical chemistry, and the practical value of this department would then be more fully appreciated than before, since the student, having acquired a greater knowledge of disease, would be in a position to appreciate the relation of chemistry to morbid processes, their recognition and their treatment.

Your sub-committee would suggest that students coming from other colleges, belonging to this Association, receive credit for work already done in the other institution, upon presentation of a certificate from the professor of chemistry, or from the dean or secretary of the other college. It would also seem desirable that students who have taken at least two years of didactic and practical chemistry in high grade literary and scientific schools, and graduates of colleges of dentistry and pharmacy should be admitted without examination to the second year of chemistry in the medical college, upon presenting a proper certificate of work from the other institution.

In conclusion, your sub-committee would state its entire agreement with the views presented by Professor Huxley a number of years ago, that the study of general chemistry has no proper place in the curriculum of a medical college; that this should precede the study of medicine, and that medical chemistry alone should be taught in medical schools. It is certainly to be hoped that this opinion may be adopted by this Association, and that, before many years have passed by, a good knowledge of general chemistry will be required for admission to Association colleges. Instruction in chemistry in the medical college, then, could be confined to its legitimate field—medical chemistry; and, with an abundance of time for its study, the subject would quickly assume its rightful place as one of the most interesting, important, and profitable parts of medical learning.

Respectfully submitted,

WALTER S. HAINES, M.D., Rush Medical College.

(To be continued.)

Kentucky State Medical Society.

Abstract of the Proceedings of the Fortieth Annual Meeting, held at Harrodsburg, June 12, 13 and 14, 1895.

FIRST DAY—AFTERNOON SESSION.

The Society convened in the court-house and was called to order by the President, DR. J. B. MARVIN, of Louisville.

Prayer was offered by the REV. DR. W. O. GOODLOE.

An eloquent Address of Welcome was delivered by the HON. BEN. LEE HARDIN.

The Committee of Arrangements then made its report.

The reports of the Permanent Secretary and Treasurer were next read and adopted.

There being no further routine business to be disposed of at this time, the reading of papers was proceeded with.

DR. WILLIAM BAILEY, of Louisville, read a paper entitled "Sanitation in Connection with Diphtheria," in which he said that in order to intelligently discuss diphtheria we must first take sanitation into consideration. Great credit was due to the work that had been done by bacteriologists. He had no new theory to advance as to the cause of the disease. It is a specific disease, due to a specific cause, which is always present when the disease exists. The consensus of opinion among those prepared to judge was that the Klebs-Löffler bacillus was the specific germ responsible for the production of the disease; hence the work to do in diphtheria was to destroy the germ or to restrict its activity. The isolation of cases should be as complete as in cases of smallpox. The room selected for the sick should, by preference, be at the top of the house and completely cut off from other parts of the house. The room should be denuded of hangings and belongings in order to facilitate the necessary disinfection afterward. Dr. Bailey then briefly referred to the antitoxin treatment in the prevention of diphtheria.

DR. CARL WEIDNER, of Louisville, read a paper on "Pathology and Bacteriology of Diphtheria." A disease which corresponds to the clinical picture of to-day seems to have existed as far back as we can trace medical history. The disease appeared in the New England States in the eighteenth century. Diphtheria was a specific disease *sui generis*. Our literature in regard to it is becoming more voluminous from year to year; and clinical investigations are following one another in rapid succession. The work of several eminent investigators was mentioned along this line. The author emphasized the importance of knowing the cause of things, and quoted the words of an eminent practitioner: "First to know, then to heal." He next dwelt upon the different micrococci, but more particularly the Klebs-Löffler bacillus. The investigations made from 1887 to 1889 demonstrated conclusively that the true and only cause of diphtheria was the Klebs-Löffler bacillus. Many investigators have since reported cases of suspected diphtheria in which the bacillus found corresponded in every way with that described by Löffler; but all cases in which the bacillus of Löffler is not found are now considered pseudo-diphtheria. From a prognostic standpoint it is important to make a distinction between diphtheria produced by the bacillus of Löffler and pseudo-diphtheria.

DR. W. MCCLURE, of Lexington, followed with a paper on

CLINICAL DIAGNOSIS AND LOCAL TREATMENT OF DIPHTHERIA.

The author showed that mere clinical diagnosis is extremely unreliable and should never be relied upon where more accurate diagnostic means are at hand. In support of this statement, he cited the fact that in 1893 the New York City Board of Health instituted a series of bacteriologic examinations, and, according to their report, examined 5,611 cases that had been clinically diagnosed diphtheria. Of this number the Klebs-Löffler bacillus was found in 3,255 cases, while in the remaining 1,540 cases no Klebs-Löffler bacilli were found. It will thus be seen that the number of mistaken diagnoses amounted to 32 per cent. The author in his argument proceeded with the assumption, which he thinks has been clearly proved, that there is no true case of diphtheria without the presence of the Klebs-Löffler bacillus, which he regards as the specific agent. In most cases there is a prodromal stage lasting a few days, resembling a catarrhal pharyngitis. There is a slight fever together with painful deglutition, more marked when swallowing liquids than solids, headache and occasional vomiting.

Of the numerous remedies used locally in the treatment of the disease, the ones that are most generally resorted to and have given the greatest satisfaction are chlorate of potassium, nitrate of silver, chromic acid, iodin, corrosive sublimate, methyl blue, tincture of iron, carbolic acid, and peroxid of hydrogen. The tincture of iron is mostly beneficial on account of the free hydrochloric acid it contains. The nitrate of silver is but a superficial caustic, while chromic acid is too heroic in its caustic effects. In peroxid of hydrogen we have a valuable adjunct in the treatment of diphtheria, when judiciously and skillfully used. It is a valuable aid in diagnosis, as by its application to the throat, if there be but a small trace of membrane, it causes it to assume a white color and on this a fine foam to rise, caused by the liberation of oxygen gas.

DR. THOMAS HUNT STUCKY, of Louisville, presented a paper on "Sequelæ and General Treatment of Diphtheria." The most important sequelæ are paralyses, which may follow mild as well as severe cases. Paralysis occurs in from 15 to 20 per cent. of the usual run of cases. In the more malignant cases paralysis occurs in about 40 per cent. The palate is most usually affected. The organ of special sense most affected is the eye. Speech, like other senses, is not involved. Brachycardia and tachycardia may be observed in the same patient. The Klebs-Löffler bacillus and streptococci have a tendency to produce exudates and pseudo-membranes. The latter are examples of mixed infection. Dr. Stucky then referred to the rapid strides that have been made by the introduction of antitoxins in the prevention of diphtheria. The most noteworthy point about the antitoxin treatment is that we know nothing about its definite composition, and no one has undertaken to give us an analysis. Supportive treatment was next referred to. The treatment may be summed up thus: 1, prophylaxis; 2, hygiene of the sick room; 3, local applications. Local treatment is of little value as a curative measure. When the lesion is once established gargles are useless. The treatment of special symptoms, such as paralysis, call for strychnia or other tonics; massage, or the electric current may be used; also the hypodermic injection of antitoxins; if there is cardiac

weakness, absolute quiet in the recumbent position should be enjoined. The hot pack is especially serviceable when dyspnea or marked nervousness is present. Stimulants and cardiac tonics should be given early in the disease and constantly. Strophanthus, digitalis, strychnia, camphor and alcohol are the remedies most in favor. Citrate of caffein may be given when the urine is scanty for its diuretic, as well as cardiac effect.

Dr. William Cheatham, of Louisville, read a paper on "The Serum Treatment of Diphtheria." The author is much in favor of the serum treatment of the disease. The method of administering it was too well known to the members for him to repeat it at this time. Practitioners, however, must practice thorough cleanliness of the parts in connection with its use. The needles should be clean. The author carries his needles in absolute alcohol. Cleanliness of the parts affected must also be carried out. The tearing away of diphtheritic membrane or any kind of rough treatment should be dispensed with and the spray and gargle substituted. The serum treatment of diphtheria is as yet in its infancy, the dose of it not being well understood. Dr. Cheatham said the best report on the antitoxin treatment of diphtheria was that made by Dr. Kinyoun, of Washington, D. C., under the auspices of the United States Marine-Hospital Service. Future possibilities in this direction could not be over-estimated, as we have in it a preventive of diphtheria. The Government of France had conferred high honors upon Roux for his investigations relative to diphtheria.

Dr. John Young Brown, of Lakeland, read a paper entitled

SOME FURTHER OBSERVATIONS ON PELVIC DISEASE AND ITS RELATION TO INSANITY IN WOMEN, WITH REPORT OF CASES.

The author emphasized the importance of this subject and showed how gynecology and surgical work of every description had been neglected in the asylums of the South. In order to become familiar with this matter he addressed a circular letter to the superintendents of thirteen asylums of Southern cities, including those of Kentucky, requesting them to inform him what per cent. of the female population suffered from pelvic disease, and to what extent operative gynecologic work had been done. In reply, he received seven letters, the majority of which admitted that a large amount of pelvic disease existed among insane patients; others knew nothing about it and had never investigated the matter. A gentleman who has served for a number of years as superintendent of one of the largest Southern asylums, confessed to him that he was prejudiced against operative interference in these cases, he having seen so many of them recover, notwithstanding the existence of marked disease, in which he had expected to do some sort of operation. Dr. Brown then referred to the pioneer work of Dr. Geo. H. Rohé in this direction, also that of Dr. Manton, who had urged that this class of patients be given the benefit of surgical interference which heretofore had been denied them. In discussing the relation of pelvic disease to insanity in women and the indications for operation, Dr. Brown wishes it to be distinctly understood that he only recognizes palpable disease as indicative of operative interference. He has very little faith in the theory of reflex neurotic troubles, without a lesion; nor does he believe that pelvic disease *per se* ever results in insanity. Dr. Brown then reported cases upon which he had operated for palpable pelvic disease, the operations being followed by relief of the mental trouble.

Dr. John M. Foster, of Richmond, contributed a paper entitled "Diagnosis of the Presentation and Position of the Fetus by External Abdominal Examination." There had come under the author's observation within the last year twenty-seven obstetrical cases, twenty-three of which were in his own practice, the other four in the practice of other physicians. In all of his own cases he saw the patient from one day to one month before confinement and made a careful examination of the abdomen by palpation to determine the position of the child. In only one case was he in doubt as to the diagnosis on account of the great tension caused by the amniotic fluid. In the first nineteen cases he found a normal position and presentation, as was afterward verified at the delivery. But the twentieth case proved to be an occipito-posterior position. The four cases seen in the practice of other physicians had each advanced too far to hope to rectify the abnormal position for they were all abnormal; one case was an occipito-posterior position, delivered with forceps after much difficulty (stillborn fetus). One footling and two breech cases, all very protracted, with a stillborn fetus in all. Having outlined the method of recognizing the normal position, the author then directed attention to a few of the leading points in the recognition of abnormal positions, saying that this was a subject the obstetrician must study for himself at the bedside in a practical manner. He urged giving obstetrical cases more attention before confinement, for by so doing we would reduce the infant, as well as the maternal mortality.

First Day—Evening Session.

The Society met at the Harrodsburg Opera House, and was called to order at 8 P.M.

The President, Dr. Marvin, delivered his Address, which was timely and listened to throughout its delivery with marked attention. Among the many things dwelt upon, he urged a more prompt publication of the Transactions.

Regarding the State Board of Health, some people had an idea that its work was simply to drive quacks out of the State. This was only a small part of its work. It has a higher duty to perform, namely, to educate the community in regard to sanitary science in order that "we may have life and have it more abundantly."

He then dwelt briefly on higher medical education and the four-year course, pointing out the great advantages and benefit to accrue from it, to both the profession and the public.

President Marvin also urged that a committee be appointed from the Society on Public Policy to work in conjunction with the State Board of Health in their efforts to protect the health of the people of Kentucky.

Dr. Joseph M. Mathews, of Louisville, followed with a popular address on "The Public Health." This address was well delivered, and punctuated here and there with applause. Dr. Mathews said in part that indiscriminate spitting in school rooms, hotels, sleeping cars should be regulated by law; that saliva, whether moist or dry, was a vehicle that brought danger and death. He then drew a picture of the consumptive in a sleeper going to the land of flowers for health, and the next day the health seeker for pleasure and recreation occupied the same berth and who, by want of cleanliness and proper hygienic prevention, was subjected to tuberculosis. In the cold northern climates much had been said with reference to transmitting the germ of tuberculosis by means of kissing, and for this reason he believed kissing was abolished in some places; but no Kentuckian had ever reached a point to forego the ecstacy and bliss arising from genuine osculation, and he would never advocate such a distressingly uncomfortable theory, although he was a firm believer in the germ theory of disease.

On motion of Dr. William H. Wathen, a vote of thanks was tendered to Drs. Marvin and Mathews for their able and instructive addresses.

Adjourned till 9 A.M. Thursday.

Second Day—Morning Session.

Dr. W. L. Rodman, of Louisville, read a paper entitled

THE RADICAL CURE OF INGUINAL AND FEMORAL HERNIA.

At the present day, surgeons were more optimistic than they ever had been, and were doing a far greater number of herniotomies than was ever known in the world's history. The limits of the operation therefore are becoming enlarged rather than restricted: 1, operation for the relief of a strangulated hernia should, whenever practicable, be supplemented by a radical cure. 2, irreducible herniæ, so-called, generally cause pain and gastro-intestinal symptoms, beside being more likely to be followed by obstruction, inflammation and strangulation, and these cases, as a class, should be subjected to a radical cure. 3, hernia accompanied with reducible hydrocele should be subjected to a radical cure. These cases will usually be found early in childhood, but he recently operated upon such a case in a young man, 22 years of age, living in La Rue County. Trusses and injections had failed to cure both the hernia and the hydrocele. The three classes already mentioned, without there be contra-indications, demand a radical cure.

Dr. Rodman then considered ordinary reducible herniæ. Here many things are to be considered; age, occupation, position, general health. Children will be usually treated and successfully so by a suitable truss. He said that, according to high authority, children under 10 years of age are invariably cured by a truss. Recent statistics, however, taken from the largest hernia clinic known, the London Truss Society, show that according to McCready more than one-third of such cases are uncured by mechanical means.

The three operations having greatest popularity at the present time are in the order named; Bassini's, Halstead's and Macewan's operations. The Bassini method is by far

the most generally practiced, though it has been somewhat modified by different surgeons. Dawbarn, of New York City, makes quite a material modification of Bassini's operation in transplanting the testicle from the scrotum to a point just inside the internal ring behind the peritoneum. Considering the statistics made during the last five years only, we find an astonishingly small fatality following this operation. Bassini reports 560 successful cases of his operation without a death; Marcy did over 200 with no mortality; Macewan 81 cases without a death, and Coley did 200 operations with one death, and this was due to double pneumonia on the eighth day, the result of ether.

DR. FREDERICK P. HENRY, of Philadelphia, Pa., read a paper entitled "Remarks on Chlorosis and its Treatment." He said the chief predisposing causes of chlorosis are to be found in age, sex and constitution. The principal of these predisposing causes is, he believes, a congenital tendency to anemia. The exciting causes are those of anemia in general, such as insufficient food, light, air, and exercise, overwork, either mental or physical, anxiety, grief, and nervous excitement in general. The anatomic characters were next considered at length. The complications of chlorosis are phthisis, gastric ulcer, chorea, and exophthalmic goitre. As regards the treatment, the remarkable efficacy of iron was referred to when used in the initial stage. Nearly all chlorotics are dyspeptic, and until the digestive disorder is relieved the full benefit of iron can not be obtained. In cases of atonic dyspepsia, the simple bitters, such as gentian or exciters of the smooth muscular fibers, such as strychnia or brucia, may be administered before meals, or if there is gastric dilatation, naphthol, salicylate of bismuth, or chloroform water may be given three or four hours after meals, as recommended by Le Gendre, in order to limit or stop the abnormal fermentation generally present in that condition.

DR. LOUIS FRANK, of Louisville, read a paper on "Treatment of Puerperal Sepsis." The author first dwelt upon the etiology and pathology of this form of sepsis. Preëxisting gonorrhea may cause sepsis, as may any pathologic condition of the genital organs which antedates delivery. The conditions are often not discovered until too late to institute prophylaxis. Notwithstanding the fact that infection is most frequently conveyed by the hands, instruments, and dressings of the obstetrician or nurse, there may also be local conditions in the genital tract below the internal os which play an active part in permitting infection, and without which it would not occur. The treatment he considered under several heads: 1, those cases where the infection is the result not directly but indirectly of tears in the soft parts, there being a localized suppuration at these points; 2, those cases where septic endometritis exists; 3, where pus tubes or sacs in the broad ligaments are found; 4, purulent metritis and parenchymatous metritis; 5, purulent peritonitis; 6, sapremia, septicemia or pyemia.

DR. CURRAN POPE, of Louisville, read a paper on

SOME REFLECTIONS ON THE CAUSATION AND THERAPEUTICS OF NERVOUS DISEASES.

The medical mind has been recently directed toward the presence and excess of uric acid in the excretions of persons suffering from various forms of nervous troubles, and some French investigators go so far as to state that nervous diseases and uric acid are one and the same thing. This is based largely upon the investigations and statements of Haig and Bouchard whose experiments are marked by unexcelled brilliancy. Dr. Pope is constrained to believe, however, that the deductions therefrom are erroneous. He believes that the position assumed by Hertor and Horbaczewski is correct, and that uric acid largely derived from nuclein is the detritus of tissue waste and a resultant of nerve functioning; in other words, the presence of uric acid is an indication and a manifestation of nutritive and digestive disturbance. It is the result of nutritive disturbances going on in the body where so many minute vito-chemic reactions take place.

Considerable experience in the treatment of all forms of nervous disease has taught the author, in many instances, that elimination must precede nutritional treatment, and he had seen few cases that had not been benefited by this line of treatment, strictly individualized in its application to the case in hand. In his opinion, hydrotherapy is by far the most satisfactory, pliable and useful remedy that the medical profession possesses, and after some years of experience with it he does not hesitate to say that he believes this agent, cautiously and carefully applied by a physician thoroughly trained in its application, to be the very best means for the correction of disordered nerve force, the elimination of waste products, and the toning of the vasomotor system.

SECOND DAY—AFTERNOON SESSION.

The first paper read at this session was by DR. H. J. COWAN, of Danville, entitled "A Case of Monocular Albuminuric Retinitis—Recovery."

DR. J. MORRISON RAY, of Louisville, read a paper on "The Blind of Kentucky."

DR. HORACE H. GRANT, of Louisville, read a paper entitled "Comparative Value of Mechanical Devices in Making Intestinal Anastomosis," and DR. AUGUST SCHACHNER, of Louisville, one on "Modern Methods of Intestinal Anastomosis."

These papers considered all known mechanical devices for performing intestinal anastomosis up to date, and the deductions drawn incline to the belief that the day is not far distant when surgeons will return to the old method of suturing the bowel without the aid of mechanical devices.

DR. HENRY E. TULEY, of Louisville, read a paper entitled

THE CARE OF THE NEWBORN.

The question of the care and management of the newborn child has so long been relegated to ignorant mothers and nurses, that a consideration of the subject by medical men is opportune. The danger of septicemia threatens every newborn child through the medium of the cord. We know that tetanus, erysipelas and diphtheria occur in the young infant, the infecting organism gaining entrance through the cord. The cord should be tied in two places, about one inch apart, with a strong ligature which has been previously sterilized, extra care being exercised in tying those cords which contain a large amount of Wharton's jelly, as the shrinkage of this may cause the ligature to slip and a dangerous hemorrhage ensue.

Relative to feeding, it is hardly necessary to state that unless some physical condition precludes, all infants should be given nature's food—mother's milk. Immediately after birth the child should be anointed thoroughly with vaselin or olive oil, not with lard, on account of the salt which it contains, then wrapped in a shawl or blanket and laid away for at least twelve hours, before it is bathed and dressed and given to its mother for the first nursing. During the first six hours the cord should be examined frequently for hemorrhage. The child's temperature should be taken twice daily for at least one week after birth. Should the child be getting an insufficient quantity of milk it will have an elevation of temperature from 1 to 4 degrees above normal.

The important precaution to prevent thrush or sprue is the regular cleansing of the child's mouth before and after each nursing, which can be done by means of a cotton swab on the finger wet with a saturated solution of boracic acid. Instructions should be given for the proper care of the buttocks.

DR. M. F. COOMES, of Louisville, read a paper on "Stricture of the Esophagus." Strictures of the esophagus occur mostly in children, and were generally due to traumatism. Cases occur more frequently in the United States than in any other part of the world, for the reason that American housewives made use of lime; whereas in England, Germany and other countries they did not use it. American children got hold of this lime and swallowed it.

DR. GEO. S. DAVIS, of Salvisa, read a paper on the "Treatment of Pneumonia."

DR. J. G. CARPENTER, of Stanford, followed with a paper on "Abdominal Surgery in the Country." He said that Dr. John Craig, of Stanford, operated on a woman 30 years of age for an abdominal tumor in 1850. There was a large sac, containing many smaller ones, all filled with fluid, and the tumor weighed fourteen pounds. The abdomen was opened in the median line, and the tumor was a multilocular ovarian cyst. Similar operations were referred to as having been done in the country in farm-houses by Dr. Craig and his assistants. Dr. Carpenter said the best results in the past had been obtained in the country in farm-houses, out of hospitals, and by country surgeons, as had been claimed both by Price and Tait.

DR. GEO. BEELER, of Clinton, read a paper on "Milk Sickness," in which he reported several interesting cases occurring in the practice of himself and others. From the aggravated character of the disease, its successful treatment requires great discrimination and experience.

DR. S. G. DABNEY, of Louisville, read a paper on "Phlyctenular Ophthalmia."

(To be continued.)

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SATURDAY, JUNE 29, 1895.

GOITRE TREATED BY THE DESICCATED THYROIDS.

At the seventeenth annual congress of the American Laryngological Association just held at Rochester, N. Y., DR. E. FLETCHER INGALS, of Chicago, read a paper on this subject, in which he presented the histories of fifty cases, recently treated by himself and others, with desiccated thyroids. An analysis of these cases and a consideration of the history of the use of the thyroid products in goitre and myxedema served to warrant the following conclusions:

Thyroid products produce marked physiologic effects upon the nervous and circulatory systems as indicated by headache, dizziness, pains in various portions of the body and great weakness; and by flushing of the face and rapidity of the heart's action. Some of these unpleasant symptoms usually occur when a daily dose is reached, corresponding to one and one-half or two entire thyroid glands of the sheep.

If the administration of the remedy in doses that cause such symptoms is continued for a few days, constitutional effects are produced indicating that persistent use of doses of from 6 to 12 grs. of the dried thyroid (equivalent to one or two thyroid glands) three times daily, might produce fatal results.

Desiccated thyroid glands appear quite as active and more stable than the liquid extract.

Internal administration appears quite as effective as hypodermatic medication.

For internal use the adult dose of the desiccated thyroids should not exceed 2 grs. three times daily, at first; but the dose may be gradually increased to two or three times this quantity, providing it does not cause unpleasant symptoms. There is no evidence that moderate doses have an injurious effect.

The remedy in some cases has a pronounced effect on the body weight, but this is very uncertain and varies so greatly in different persons and in the same individual at different times that there is strong reason for suspecting that the loss of weight that sometimes follows this administration may be due entirely to disturbance of the digestive organs.

In the treatment of myxedema, the remedy has undoubted value and appears to benefit quite a large percentage. In these cases it is probable that the best results will be obtained by giving it at intervals for a long time.

In exophthalmic goitre the remedy causes rapid reduction in the size of the gland, but it has but little if any effect upon the exophthalmos, and it apparently aggravates the heart symptoms. In this disease it must be used guardedly, and its effects must be carefully watched.

In many cases of goitre, internal administration of full doses of the products of the thyroid is followed by a most remarkable diminution in the size of the diseased gland. Improvement or cure may confidently be expected in 76 per cent. of the cases, but sufficient time has not yet elapsed to determine what the final results will be. It is probable that cystic growths in the thyroid gland would not be influenced by this remedy.

Clinical experience has not yet demonstrated that this remedy is of value in other diseases, but its effect in diminishing the size even of very firm and hard enlargement of the thyroid gland would certainly justify experimentation in other directions.

QUININ OR ARSENIC IN CHOREA.

DR. PHILIP C. KNAPP writes, in the *Boston Medical and Surgical Journal*, that he has, at the City Hospital, given quinin a trial, not on an extended scale, according to the suggestion of DR. H. C. WOOD made in 1893 before the Association of American Physicians. The results of this trial were not so favorable as appeared to have been obtained by DR. WOOD, but in one case there occurred a complete recovery within a week, and in another within three weeks. But inasmuch as all choreas are not the same, nor from a like etiologic source, it is not unreasonable to suppose that quinin may serve as usefully as arsenic in a proportion of the cases.

DR. KNAPP did not feel sufficiently encouraged by this trial to extend it to his private practice. On this point and on the varieties of the affection he remarks as follows:

"Choreic movements are not uncommon as a result of structural brain disease, but they are rarely, if ever, seen as a symptom of diseases of the cord. In canine chorea, on the other hand, which is not proved to be the same as human chorea, the changes are chiefly in the cord. It is possible that in some

cases, such as those reported to the American Neurological Association in 1890 by WEIR MITCHELL, the morbid process may affect chiefly the cord, but such cases are rare.

"It is furthermore possible that in the future we may differentiate several affections which are now called chorea. HUNTINGTON'S chorea and the electric chorea of DUBINI are now fully recognized as distinct diseases, having no connection with the ordinary chorea of childhood—SYDENHAM'S chorea. Evidence is accumulating that in most cases of SYDENHAM'S chorea we have to do with a disease of microbic origin, and the researches of BERKELEY, DANA and PIANESE have done much to confirm that belief. Other cases, including some of the rather rare cases which are alleged to be due to fright or to irritation, may be of hysterical origin. In chorea of microbic origin the toxin probably exerts its chief influence upon the brain cortex, especially in its motor region.

"The hypothesis on which quinin is recommended for the treatment of chorea seems to me untenable, and the therapeutic results are based thus far on too few cases to warrant us in ascribing greater virtues to this drug than to arsenic. Not having the idea at the time of publishing the results of this very imperfect trial of the drug, the results of one season's trial did not seem to me of sufficient value to lead me to try it in my private practice or in my subsequent terms of service at the hospital, and I went back to my former custom of supplementing the rest and regimen with full doses of arsenic, associated if necessary with iron or other tonics, and, in case of great motor disturbance and restlessness, with sulphonal or other sedatives."

OCULAR SYMPTOMS OF THE LITHEMIC STATE.

Lithemia is not latent or suppressed gout, it is a modified form of gout. It is the form which is particularly prone to manifest itself in this country, and has on this account been styled American gout by DA COSTA[1], who by his writings has contributed largely to our knowledge of this peculiar morbid state. The term, lithemia, is not entirely satisfactory, since the condition intended to be described involves much more than a mere excess of uric or lithic acid in the blood or urine. The blood contains urates in excess and frequently oxalates, also other imperfectly elaborated products of waste, such as xanthin and paraxanthin; possibly it may yet be further poisoned, as suggested by the same authority, by the absorption of ptomaines, or toxalbumins, resulting from imperfect gastric and intestinal digestion. The urine is, as a rule, increased in density and in its content of coloring matter, and is acid in reaction; but spontaneous deposits of urates and of uric acid are seldom observed; small quantities of albumin may sometimes be found and even tube casts, both hyalin and epithelial, but these are only transitory and do not indicate permanent kidney disease. While a deposit of urates in the vicinity of the joints does not occur, and attacks of acute arthritis are rare, there is a painless enlargement of the phalangeal joints with some impairment of function, especially observed in elderly people. The blood tension may be normal, or moderately increased in lithemia, but it is so to a less degree than in typical gout, and the arteries do not so readily tend to the atheromatous condition; neither do the heart or kidneys present the usual gouty changes. There is no acute exacerbation of joint inflammation in lithemia, as there is in true gout, such attacks, according to TROUSSEAU'S teaching, being conservative and therapeutic efforts of nature to relieve the condition, but there are other disturbances which are not entitled to be considered so favorably.

Among the usual symptoms have been enumerated, impaired digestion and a tendency to acid or fermentative dyspepsia, muscular pains, neuralgic attacks, pains in the tendons, malaise and indisposition to exertion, drowsiness during the day, lack of ambition, depression of spirits, frequent and severe attacks of vertigo and migraine, restlessness, insomnia and jerking muscles at night. One consequence of defective oxidation and deficient elimination and of the excess of food supply, is that the functions of the liver are imperfectly performed and there is generally more or less hepatic disorder, with its attendant symptoms.

The ocular affections associated with lithemia have quite recently been reviewed by S. D. RISLEY of Philadelphia, in a paper read at the State Medical Society of Pennsylvania. Very much has been said and written, directing attention to eye abnormalities as the cause of irregularities of function in remote organs, producing symptoms which are liable to be mistaken for cerebral, gastric, hepatic, renal, spinal or nervous disease. Even chorea and epilepsy have been traced to this cause and cases have been effectually relieved by appropriately selected glasses.

It has also been shown *per contra* that general disorders having their principal lesions in the great nerve centers, like locomotor ataxia, or in the blood, as in syphilis and tuberculosis, or remote organs and tissues, as in Bright's disease of the kidneys, or in disordered metabolism, as in gout and rheumatism—may each give rise to characteristic changes in structure and disturbance in function of the organs of vision. Directly in this connection, RISLEY calls attention to the fact that lithemia is both a primary and a modifying factor in many ocular discomforts and even the efficient cause of many serious diseases of the eye. The great liability of gouty subjects to transient vasomotor derangements, to persistent and recurrent inflammations of mucous membranes and fibrous tissues, and to degenerative changes in vascular walls is generally recognized, and in its modified form, as lithemia, something of the same character might be looked for in an organ like the eye, in which these structures are represented in such a highly organized form.

1 The Pathology of Lithemia, Medical News, March 17, 1895.

In the etiology of iritis, lithemia stands second only to syphilis in the number of the victims, while in obstinacy and tendency to recur it stands first. But there are other forms of ocular disturbance which are less well known than rheumatic iritis, or irido-cyclitis, as it is called, and in the treatment of which the same causative factor should not be overlooked. In such cases, local measures are useless and the patient will not begin to recover until the diet is regulated and the appropriate remedies given. Among these disorders is the conjunctivitis of children which is not infrequently associated with impaired alimentation and imperfect assimilation of food. In adults, also, conjunctivitis may have this origin, while episcleritis is a very common manifestation of lithemia.

Some disorders of refraction, producing weak eyes, and evidences of eye strain, which apparently admit of easy correction are found not to be much benefited by appropriate glasses. Such a patient may go from one clinic to another, until some one recognizes in the sedentary life and badly selected diet the efficient cause of an underlying lithemia, and directs the patient to the path which leads to recovery, both of vision and of health.

RISLEY declares that a large number of patients with habitually weak eyes, who receive glasses of low power for the correction of minor defects of refraction, are victims of this diathesis. They suffer from every attempt to use the eyes at near work, their symptoms being out of all proportion to the amount of abnormality which can be detected. Low grades of muscular anomaly, varying in kind and degree from day to day, may be observed. The ophthalmoscope reveals an injected nerve and choroid, but no gross change, except that if the patient be past middle life and the diathesis of long standing, there may be found well-marked striation of the retinal fiber layer and granular—or it may be, gray—borders to the retinal vessels, together with a cinnabar red and woolly eye ground. The symptoms may entirely disappear if the patients get a few days' outing, and they may then lay their glasses aside, owing to improved metabolism and increased excretion brought about by exercise. This of itself is indicative of the systemic origin of the symptoms, especially if the latter return upon resuming the former sedentary habits of life.

In well-advanced cases with general arterial changes, serious lesions may occur in the eye. Thus innumerable small apoplexies may be observed in hemorrhagic retinitis, even peri-vasculitis, hemorrhagic glaucoma, and the choroidal disease which precedes incipient cataract may be detected; the changes in the circulation in the eye going on progressively in association with those of the general vascular system. The importance of the early recognition of the real character of these changes is obvious, and the information gained by ophthalmoscopic examination will enable the physician to institute appropriate measures to prevent the further progress of the disease or, at least, to materially delay its development. Some forms of corneal disease—glaucoma, hemorrhagic retinitis, albuminuric retinitis and peri-vasculitis should always lead to a careful analysis of the case, since they may prove to be but one of several groups of symptoms pointing to the general impairment of the vital functions attending the lithemic state. Incidentally, it is to be observed that the results of surgical operation in advanced cases, especially in elderly subjects, are greatly impaired by the presence of lithemia, and in cataract extractions, iridectomies and other operations, in such profoundly diseased eyes, the surgeon, if he is wise, will give a doubtful or a guarded prognosis.

GRAPHOLOGY.

PROFESSOR WM. PREYER, whose work in physiology and physiologic psychology is well known and highly valued, has recently published a work on the "Psychology of Handwriting," which is, for three-fourths of its volume at least, a treatise on graphology or the science or pseudo-science of determining personal traits and character from handwriting. Another prominent medical scientist, LOMBROSO, has entered the same field, and it may therefore be considered as not undeserving of notice, the more especially as it is, in the natural order of things, likely to attract popular attention and become more or less a fashionable fad of the day. Its literature is increasing and it has various elements of popularity. Its sanction or support by such eminent medical authorities goes far to render it respectable—in short, it seems to have a future, at least a temporary one.

The pathology of handwriting has an admitted importance and has been ably studied by ERLENMEYER, GOLDSCHEIDER and others. PROFESSOR PREYER, however, goes farther and holds that its psychology must be studied by the physician, that the neuropathologist must examine the handwriting for character, simulation, emotional condition, etc. That there may be a germ of truth in this may be admitted, but there is a serious prospect of false diagnosis if this method is to be generally adopted and its results accepted according to the dicta of the graphologist. What are we to say of the ataxic, drunken-appearing signature of SHAKESPEARE, for example, to say nothing of many eminent men whose handwriting would indicate mediocrity, not to mention qualities positively vicious, according to the graphologic signs? Such examples can be found abundantly, and do not speak well for the accuracy of the indication.

Moreover, graphologists are not all in agreement as to the value of features, and one sees rectitude

where another might suspect deceit. The possible gross injustice that may thus be done, in individual cases, will be obvious to any one.

The fact is, handwriting is an artificial accomplishment and is affected by so many factors that a perfectly natural and characteristic one is probably more of a rarity than many would suspect. As an indication of character it is a dangerous guide and ought, at best, to be only used by especially skilled observers, who themselves should draw their own conclusions with reserve, and ought to hesitate before laying down formal directions for the guidance of others.

For medical purposes the study has a value, but more from a pathologic than a psychologic point of view, and the recommendation of its use should be limited to the study of its disorders in disease. The germ of truth that exists in the popular graphology of the day, is not enough to give the latter the rank of an accepted science, even with the support of high authorities like PREYER and others.

A RIVAL TO PERKINSISM.

"No wretch e'er felt the halter draw
With good opinion of the law."

The State of "Missouri has a Still," says the *Medical Fortnightly*, "that never rests." It is DR. STILL, the so-called "Osteopath."

One of the down-trodden worms of this Still—JAMES STROTHERS—is located at Roseville, near Monmouth, Illinois. He issued a circular in the *Roseville Times*, May 3, 1895, in which he made the usual tirade of irregulars and miscellaneous rascals, generally, against the Practice of Medicine Act of Illinois, and the State Board of Health, on account of his arrest by that Board. This circular which sets forth the grievance of the "Osteopaths" was reprinted from the *Roseville Times* and distributed to the members of the Illinois Legislature. May 28, MR. HAMER introduced into the State Senate the following:

A BILL

For an Act to amend Section ten (10) of an Act entitled, "An Act to regulate the practice of medicine in the State of Illinois," approved June 16, 1887, in force July 1, 1887.

SECTION 1.—*Be it enacted by the People of the State of Illinois, represented in the General Assembly*, That section ten (10) of an Act entitled, "An Act to regulate the practice of medicine in the State of Illinois," approved June 16, 1887, in force July 1, 1887, be amended to read as follows:

SEC. 10.—Any person shall be regarded as practicing medicine, within the meaning of this Act, who shall treat, operate on, or prescribe for any physical ailment of another.

But nothing in this Act shall be construed to prohibit services in case of emergency, or the domestic administration of family remedies, or the practice of "Osteopathy," or to commissioned surgeons of the United States Army, Navy or Marine-Hospitals service in the discharge of their official duties.

The first three lines attracted no attention on the part of any reader and the affair was managed very quietly and actually passed the Senate, and but for the watchfulness of the Committee on Legislation of the Illinois State Medical Society, and DR. JOHN L. WHITE, of the House, would have passed both houses without attracting any particular attention.

It seems that the original Osteopath, "DR." STILL, has a "college," the "American School of Osteopathy," located at Kirksville, Mo., from which emanate such hopeful worthies as STROTHERS.

DR. STEELE, of St. Louis, who investigated the matter, read a paper on the subject before the Missouri State Medical Society, of which the *Fortnightly* gives an abstract:

"The question is now often asked, What is osteopathy? It may be said to be a 'school of medicine' of which one STILL, of Kirksville, is the disciple, which has developed to such an extent as to have a 'college' from which numerous 'graduates' are being sent out; which has had a trial for a law of recognition, which bill passed both houses of the recent Legislature, and would have gone upon the statute books had it not been wisely vetoed by GOVERNOR STONE. All thanks to him for having saved the State from disgrace! The 'graduates' of this 'school' do not need any special training in anatomy, physiology or therapeutics, as the whole system is summed up in one proposition: all diseases are due to the displacement of bones and consequent pressure on nerves and other tissues. The summary of treatment is simplicity itself: reduction cures. There are two kinds of disease: 1, one from displaced bones of the extremities, causing deformities, pain, etc.; 2, the other, dislocation of some of the vertebræ, giving rise to trunkal diseases. But the same treatment cures all. The stock of knowledge, therefore, consists in the knack of manipulation, with perhaps an element of hypnotism—certainly a large amount of suggestion. In this, very like Christian science, certainly many cures are effected, the classes benefited being four: 1, old adhesions following sprains, rheumatism, etc., which can be broken up; 2, cases where there is really no pain or tenderness in a joint but the patient has lost its use through fear; 3, hysterical cases; 4, old dislocations, real. The regular profession has been derelict in not recognizing and curing such cases."

Osteopathy as it is practiced, thus appears to be massage, pure and simple, and DR. STEELE has not quite done justice to modern teaching, which recognizes fully the indications for massage and the correct methods of its application. The masseur has come to stay, but we do not like to see him masquerading under the name, osteopath. A masseur of the first order must thoroughly understand the anatomy of the body. Now-a-days when the masseur is as indispensable to the general practitioner and the surgeon, as the trained nurse, he is so much in demand that no excuse can be offered for his adherence to theories such as are propagated by this veriest moonshiner of all the illicit stills in the country. Let the masseur stick to his art.

RAILWAY ACCIDENTS AND MORTALITY.

From advance sheets of the "Abstract of Statistics of the Railways of the United States" for the year ended June 30, 1894, we learn that, "during the year

1,823 railway employes were killed and 23,422 were injured, as compared with 2,727 killed and 31,729 injured in 1893. This marked decrease in casualty is in part due to the decrease in the number of men employed, and the decrease in the volume of business handled. The increased use of automatic appliances on railway equipment also may have rendered railway employment less dangerous and it may be that the grade of efficiency of employes has been raised.

"The number of passengers killed was 324, an increase of 25, and the number injured was 3,304, a decrease of 195. Of the total number of fatal casualties to railway employes, 251 were due to coupling and uncoupling cars, 439 to falling from trains and engines, 50 to overhead obstructions, 145 to collisions, 108 to derailments, and the balance to various other causes not easily classified. To show the ratio of casualty, it may be stated that 1 employe was killed out of every 428 in service, and 1 injured out of every 33 employed. The trainmen perform the most dangerous service, 1 out of every 156 employed having been killed, and 1 out of every 12 having been injured.

"The ratio of casualty to passengers is in striking contrast to that of railway employes, 1 passenger having been killed out of each 1,912,618 carried, or for each 44,103,228 miles traveled, and 1 injured out of each 204,248 carried, or for each 4,709,771 miles traveled. A distribution of accidents to the territorial groups exhibits the diversity in the relative safety of railway employment and of railway travel in the different sections of the country."

CORRESPONDENCE.

Utah State Medical Society.

SALT LAKE CITY, UTAH, June 18, 1895.

To the Editor:—In February of the present year, a Utah State Medical Society was organized, its members comprising almost all of the best known physicians in the Territory. The Code of Ethics of the AMERICAN MEDICAL ASSOCIATION was adopted. The first annual meeting will be held Oct. 1 and 2, 1895. The following is a list of officers elected: President, F. S. Bascom, M.D.; First Vice-President, Walter R. Pike, M.D.; Second Vice-President, G. M. Perkins, M.D.; Secretary, J. N. Harrison, M.D.; Treasurer, G. M. Wilson, M.D.

J. N. HARRISON, M.D., Sec'y.

A Question of Translation.

WHEELING, W. VA., June 19, 1895.

To the Editor:—In the Correspondence column of the JOURNAL, I notice a letter by Dr. Chas. G. Kuhlman with the heading, "*Audi Alteram Partem*." I note a very serious mistake. At the close of his letter the Doctor correctly quotes Binz, as stating in 1883 at the Buda-Pesth Congress for Internal Medicine: "Our future therapeutic efforts in infectious diseases must be toward '*Den lebenden organismus zu entgiften.*'" This he translates, however, in parenthesis: "To poison the organism, as it were." But, *entgiften* means just the opposite, viz., to remove or eliminate poison. Therefore Dr. Kuhlman has no reason to take issue with Binz on this doctrine, as they are both of the same opinion as the majority of the American medical profession, who will "continue in the future as they have done in the past—to eliminate the contagium at the bedside." It is sometimes dangerous to make a translation when not perfectly familiar with the respective languages.

Respectfully, G. A. ASCHMAN, M.D.

BOOK NOTICES.

On the Symptoms which Simulate Diseases of the Pelvic Organs in Women, and Their Treatment by *Allo-piesto-Myo-Kinetics* (Massage), and by *Auto-Piesto-Myo-Kinetics* (self-movements of muscles under pressure). By A. RABAGLIATI, M.A., F.R.C.S., Ed., Honorary Gynecologist, late Senior Honorary Surgeon, Bradford Infirmary. Octavo, illustrated by six full-page heliogravure plates, extra muslin, pp. 77. Price $1.50. New York: William Wood and Company. 1895.

Those who have *in propria personæ* experienced the full benefits of massage, as demonstrated on a debilitated and plethoric body, will, we feel sure, yield to the enthusiastic masseur and masseuse the meed of praise to which they are entitled. But there must be some limit even to the uses of massage. We may concede that massage is the very best form of administering concentrated exercise, and that wherever and whenever exercise may be beneficial, massage, its "concentrated extract," is indicated, and yet we must deny that massage can prevent microbic invasion, arrest malignant disease, or restore lost parts.

We, however, freely concede that adhesions may be broken up, that circulation may be improved, and neuritis relieved by proper use of massage. And there is little question but many cases treated in the past few years by oöphorectomy would have been better treated by rational massage, and self-movements of muscles, as advocated by our author. The book is interesting and valuable.

Transactions of the American Association of Obstetricians and Gynecologists. For the Year 1894. Vol. VII. Octavo, cl., pp. 520. Philadelphia. 1895.

We have already published in this JOURNAL a full account of the last meeting in Toronto of this flourishing society, and given abstracts of the papers. It only remains, therefore, to chronicle the appearance of this handsome volume, which makes the seventh of an interesting series, and adds to the current literature very much that is of permanent value. The volume is larger than its predecessor, and its typography is excellent.

The Care of the Baby. A Manual for Mothers and Nurses, containing Practical Directions for the Management of Infancy and Childhood in Health and Disease. By J. P. CROZER GRIFFITH, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania. Octavo, cl., pp. 392. Price $1.50. Philadelphia: W. B. Saunders. 1895.

To the already large number of guides to mothers and nurses, this treatise has been added. There are eleven chapters written in popular style, and fairly illustrated. The physician may find it convenient to recommend a book to his patients, and this of Dr. Griffith seems to meet the want. Many a baby will be better cared for when the mother becomes familiar with the contents of this book. We commend it.

The History of Prostitution, ITS EXTENT, CAUSES AND EFFECTS THROUGHOUT THE WORLD. By WILLIAM W. SANGER, M.D., Resident Physician, Blackwell's Island. With numerous editorial notes and an appendix. 8vo, cl., pp. 709. New York: The American Medical Press. 1895.

The investigation of which this book is the outcome was begun in 1855, and completed in 1858. An appendix brings the results down to date. The author arrives at the only conclusion to which an unprejudiced mind can come after careful investigation, namely, that the evil, which has existed in all ages, can not be totally suppressed by any legislative measures whatever, that its calamitous results may be diminished by proper regulation, and that the number engaged in prostitution may be measurably diminished by increasing the opportunities for respectable employment, and that so far from discouraging the employment of women in the

shops and lighter trades, that every encouragement should be given to dependent young women to engage in such pursuits.

The usefulness of this book is most apparent to those engaged in the work of public charities and corrections, and the civic legislator may here find many precedents to guide him in his search for a remedy for the present rather depressing state of things as shown by municipal statistics.

Atlas of Clinical Medicine. By BYRON BRAMWELL, M.D., Assistant Physician to the Edinburgh Royal Infirmary. Vol. III, Part 2. Edinburgh: F. and A. Constable, University Press. 1895.

The second part of the third volume of this excellent work in clinical medicine has just appeared. Like its predecessors, it is a very interesting number, dealing with congenital syphilis, progressive muscular atrophy, the progressive muscular dystrophies, points to be observed in the clinical examination of cases of pseudo-hypertrophic paralysis and other forms of progressive muscular dystrophy, and [illegible]s of cases of pseudo-hypertrophic paralysis and other forms of progressive muscular dystrophy.

There are ten plates, with numerous illustrations of the text. Two of ichthyosis, one of multiple cancer of the breasts and other organs, four of congenital syphilis, two of progressive muscular atrophy, and one of cyanosis. In addition, there are numerous illustrations scattered through the text.

It is one of the best numbers issued in this useful work.

PUBLIC HEALTH.

Leprosy in Norway.—According to the most recent statistics, furnished by Dr. E. Kaurin of Molde, leprosy is disappearing more and more in Norway. In 1856 there were about three thousand lepers in that country; at the end of 1892, there were not over eight hundred or nine hundred, half of whom were inmates of the leper asylums. Since then the number has so much decreased that it is proposed very soon to close two of the five asylums in the country. The author's opinion is that leprosy is an exclusively contagious affection and that heredity is not to be regarded as a predisposing cause. Strict segregation of lepers is, he believes, absolutely necessary in order to stamp out disease.[1]

Prophylaxis of Paludism.—Noel, after passing in review the successes and failures of quinin and certain of its salts in the prophylactic treatment of malaria, reaches the following conclusions: 1, the prophylaxis of paludism by quinin is a demonstrated fact; 2, there are no inconveniences attending the treatment in health, and quinin loses none of its efficacious properties in cases of intermittents; 3, the hydrochlorate of quinin is the best salt to use; 4, the drug should be taken each morning after arrival in the dangerous zone and during its passage; 5, the minimum daily dose is 0.30 grams. For troops on the march the pill form is preferable, but for those in camp it is better to use the medicament form an ingredient of a tonic. Notwithstanding the efficacy of quinin, in the light of recent knowledge that malaria is waterborne, the true prophylactic is pure water.[2]

Cholera and Life Insurance.—Dr. Oertel, the German bacteriologist, who died in Hamburg in September, 1894, from "laboratory cholera" had his life insured in favor of his mother. It will be remembered that the Doctor contracted the disease in the course of his experiments, but it was never possible to exactly determine the manner of infection either before or after death. The policy read that the amount was to be payable in case of "violent and sudden accident, independent of the will of the assured, and determined by an external mechanical cause." After the Doctor's death the company refused to pay the policy and the matter was referred to the Hamburg Court of Appeals, which has decided that "the multiplication of the bacilli and the effects which these produce on the stomach and intestines are to be regarded as a chemical and not a 'mechanical' action."[1]

Vaccinal Dermatoses.—The dermatoses of vaccinia, no matter what their morphologic differences—erythematous, papular, vesicular, pemphigoid—agree in appearing from the ninth to the eleventh day, according to Hervieux, or on the eighth day according to Dauchey. In certain cases the eruption may appear earlier or, on the contrary, it may be later. The eruption appears without any modification of temperature; it is ephemeral, never contagious and rarely itches. These vaccinal eruptions are rare, they are nearly always observed in children, exceptionally in adults, and are more frequent in summer than in cold weather. Hervieux thinks they are due to the virus, and Behrend ascribes them to individual idiosyncrasy. While this question is still disputed, the influence of individual predisposition is undeniable. The pathogeny of these dermatoses is not yet well established. Some authors, as Morris, attribute them to reflex nervous action; others, as Behrend, claim they arise from the passage into blood, either of the vaccine virus itself, or from pus microbes from the pustules or their soluble products. The most frequent eruptions are a rash, of which Conget distinguishes four varieties—erythematous, morbiliform, papular and nettle-rash. Vaccinal malaria is equally frequent. Pemphigus is rare as is also purpura. It is interesting to note that while some skin lesions, like eczema and psoriasis, are favored by the development of vaccinia, the latter does not produce them but only encourages their development.[2]

A State Vaccine Farm.—The Illinois Legislature at its last session passed the following:

An Act to establish a Vaccine Laboratory and making an appropriation therefor.

SECTION 1.—*Be it enacted by the People of the State of Illinois, represented in the General Assembly*, That the sum of three thousand ($3,000) dollars be hereby appropriated, out of funds not otherwise appropriated, for the purpose of establishing, equipping and maintaining a laboratory in connection with the State University at Champaign, for the propagation of pure vaccine virus.

SEC. 2.—That the Trustees of said University shall have the management of said institution, *Provided, however*, that the State Board of Health shall exercise supervision of the methods of propagation and shall certify to the purity of all products.

SEC. 3.—That the product of the vaccine laboratory shall be furnished all physicians and Health Officers, within the State at the cost of propagation.

SEC. 4.—That a report of the management, together with a statement of the receipts and disbursements, be made and included in the annual report.

The passage of this Act is one of the measures which the Legislative Committee of the Illinois State Medical Society advocated and pushed. The State Board of Health also commended the bill, but the active efforts of Drs. John L. White, of the Legislature, Graham of Chicago, and Maxwell of Mt. Carmel, alone secured its passage.

Health Reports.—The following health reports have been received by the Supervising Surgeon-General M.-H. S.:

SMALLPOX—UNITED STATES.

Arizona: Nogales, June 17, 4 cases, 1 death.
Michigan: Detroit and Olivet, smallpox reported present June 8 to 15.
Missouri: St. Louis, June 8 to 15, 3 cases, 1 death.
Tennessee: Memphis, June 8 to 15, 2 cases.

[1] Le Semaine Medicale, June 5, 1895.
[2] Le Bulletin Medical, No. 29, 1895.

[1] Le Semaine Medicale June 5, 1895.
[2] Patovi in Presse Medicale de Leige, No. 15, 1895.

SMALLPOX—FOREIGN.

Belgium: Antwerp, May 24 to 31, 5 cases.
Cuba: Havana, June 6 to 13, 9 deaths.
England: London, May 25 to June 1, 20 cases; Manchester, May 25 to June 1, 1 case.
Gibraltar: May 26 to June 2, 2 cases.
Holland: Rotterdam, June 1 to 8, 3 cases.
Hungary: Buda-Pesth, May 27 to June 3, 3 cases.
India: Calcutta, May 4 to 11, 102 deaths.
Ireland: Dublin, June 1 to 8, 10 new cases, 3 deaths.
Italy: Bologna, June 1 to 8, 1 case; Naples, June 1 to 8, 1 case, 1 death.
Russia: Batoum, May 28 to June 4, 4 cases, 3 deaths; Moscow, May 18 to June 25, 1 case, 1 death; Odessa, May 25 to June 1, 8 cases, 3 deaths; St. Petersburg, May 18 to 25, 6 cases, 2 deaths; Warsaw, May 25 to June 1, 1 death.

CHOLERA—FOREIGN.

India: Bombay, May 7 to 14, 3 deaths; Calcutta, May 4 to 11, 47 deaths.
Japan: Hiogo, May 18 to 25, 4 cases, 1 death.

YELLOW FEVER—FOREIGN.

Cuba: Havana, June 6 to 13, 6 cases, 4 deaths.
Mexico: Vera Cruz, June 6 to 13, 4 deaths.

NECROLOGY.

JOHN MARSHALL HAWKES, M.D., of New York City, died May 25, aged 47 years. He was a native of East Windsor, Maine. He graduated from the College of Physicians and Surgeons, New York, in 1890. He took up his residence in New York after graduating and gave his attention largely to orthopedic surgery. He was known to the profession as an adept in the so-called paper jacket for the relief of disease of the spine. He was a widower and is succeeded in practice by his son and former co-partner, Dr. Ray Harlan Hawkes, who was graduated three years later than his father.

GILBERT DUDLEY SALTONSTALL, M.D., died at Hoboken, N. J., on June 17, from acute enteritis. He was 66 years old and graduated in 1852 at the New York University Medical School. About fifteen years ago he became the Chief Inspector to the Hudson County Board of Health. His popularity was shown two years ago, when his term expired and another physician was appointed as Inspector. The indignation aroused was so intense that the Health Board reconsidered its action and reappointed Dr. Saltonstall. He leaves a widow and three children, a son and two daughters. He was a descendant of Sir Richard of that name, once Lord Mayor of London, and likewise of Gurdon Saltonstall, Governor of Connecticut from 1708 to 1734. He had something more than a local repute as a playwright and versifier.

SOCIETY NEWS.

Mississippi Valley Medical Association.—The arrangements for the twenty-first annual meeting of this association are about complete. In response to the general invitation sent out in May, many letters are being received daily by the secretary. These letters are largely acceptances, and the outlook for the Detroit meeting in September is indeed bright. A number of excellent papers have been already received, and the scientific treat in store for those attending the meeting, will amply repay them for the trip. The profession of Detroit promise a most delightful week socially; the ladies are especially urged to attend the meeting, and by their presence add to the enjoyment of the social pleasures. There is no more delightful season in which to visit the picturesque city of Detroit than the late summer. Located within a short distance are many beautiful river and lake resorts, making it possible to arrange some very pleasant side trips. Lay aside your professional burdens during the first week in September, go, with your family, to Detroit, enjoy the intellectual feast during each day, and in the evening hours partake of the bountiful hospitality which the profession and good citizens of the city will extend to you.

FREDERICK C. WOODBURN, Secretary.

Colorado State Medical Society.—The twenty-fifth annual meeting of the Colorado State Medical Society was held in Denver June 17, 18, 19 and 20 inst. The following officers were chosen for the ensuing year: President, J. B. Perkins, of Denver; First Vice-President, E. R. Axtell, of Denver; Corresponding Secretary, A. J. Robinson, of Aspen. The meeting was the largest the society has ever held. Prof. Victor Vaughan, of Ann Arbor, and Prof. John Ridlon, of Chicago, read papers before the society.

SELECTIONS.

A Case of Spontaneous Rupture of the Heart.—(Szegetó). The body of a 67-year old woman, suddenly deceased, was brought to police examination. On the posterior wall of the left side of the heart, at a thinned area, was a fissure 8 m.m. long, through which about 300 gm. of blood had poured into the pericardium. The immediate cause of death was this rupture. The heart muscle was fatty degenerated, and an endarteritis deformans was present, while both kidneys were shrunken.—*Wiener klinische Rundschau*, May 5, 1895.

Multiple Spleens.—Albrecht showed before the Association of Physicians in Vienna a case of multiple spleens, entirely unique. Scattered over the whole mesentery were more than five hundred spleens from the size of a pin to a walnut. Of the latter size was the one located in the normal place, and this had a normal artery and vein. Every one had a capsule and normal stroma, though very deeply pigmented. Toldt designated the case as without a parallel in literature, or an analogue among all vertebrate animals, and the development of which was difficult of explanation. The spleen is normally developed by an epithelial proliferation of the mesogastrium, in which later the connective tissue of the mesogastrium develops abundantly. It may be conceived, that in this case other portions of the peritoneum as well have acquired the capacity of spleen production. Weichselbaum discussed the question of the functional capacity of these multiple spleens. He drew a conclusion in favor of defective function both from the vicarious hypertrophy of lymph glands and from the unusual pigmentation.—*Wiener klinische Rundschau*, May 5, 1895.

Suppression of Leucocytosis after Injection of Bacteria.—(R. F. Müller, Inaug. Diss. Berlin, 1894.) Just as A. Schmidt and his school have proved for fibrin ferment, peptone, hemialbumose, and Goldscheider and Jacobs for splenic extract and bone marrow, so according to experiments of the writer, intravenous injection of bacteria causes at once a relative diminution in the number of leucocytes in the large veins. Cultures of bacillus pyocyaneus, potato bacillus streptococci, and bacilli of putrefaction were injected principally into the jugular vein of rabbits under ether. Within a half hour after, various organs, as heart, liver, spleen, bone marrow were removed from the yet living animal for microscopic examination. Blood taken from the femoral vein showed a marked diminution in the number of leucocytes, —for instance, in one case one and one-fourth hours after the injection of 8 c.c. of culture of potato bacillus 16,200 were demonstrated in 1 cubic millimeter, while two and three-fourth hours after only 3,200 were present. But in the pulmonary capillaries leucocytes were very numerous. In consequence of this engorgement of leucocytes and the slowing of the blood current most of the bacteria were here filtered out. So it is shown that bacteria were found more abundant in the capillaries of the lungs than in other regions. They lay free and extracellular for the most part, and to a limited extent inclosed in leucocytes or endothelial cells. Mechanical reasons bring it about that in the

kidneys the glomerular vessels contain the largest numbers of bacilli. So after the injection of pyocyaneus cultures, bacilli were abundant in the glomeruli and mostly disposed along the walls; here also a part only lay in within the leucocytes. Of these lying extracellular many were adherent to leucocytes or red blood corpuscles. Bacilli were few in numbers in the liver and spleen, also in the remaining vessels of the kidneys.—*Centralblatt für Physiologie*, June 1, 1895.

MISCELLANY.

Dr. John V. Shoemaker of Philadelphia, has had the degree of LL.D. conferred upon him by Dickinson College of Carlisle, Pa. Dr. Shoemaker was graduated at Dickinson College in 1872, and is now Professor of Dermatology in the Medico-Chirurgical College of Philadelphia.

Nathaniel Hawthorne on "the Bible Oath."—The *Independent* thus refers to the unsanitary "kissing the book:" "Any one who has acted as a witness in court and kissed the court Bible in taking the oath should understand the sanitary reasonableness of Pennsylvania's new law to dispense with the kissing. Nathaniel Hawthorne described the Bible he used for administering oaths to American waifs and strays who came to his consulate in Great Britain as 'greasy with perjuries.'"

Creosol.—Ballaud and Dubois have given the name creosol, to a combination of tannin and creosote, containing 60 per cent. of creosote and 40 per cent. of tannin. It is a deep brown-colored powder, very hygroscopic, completely soluble in water, alcohol, glycerin and acetone; insoluble in ether, and its reaction is neutral. In concentrated solution, its taste is astringent, but without any caustic effects. This medicament may be used in inflammatory affections of the laryngeal, tracheal and bronchial mucous membrane. In adults the average dose is 5 grams daily; in children 0 gr .25; for the latter it may be prescribed as many times daily as the child is years old.[1]

The Orbital Arches and Frontal Sinuses in the Insane.—In a study of the crania of the insane, Gianneli points out that: 1, the most projecting arches are found in men; 2, in male crania a marked projection of the arch is more frequent than a large sinus; 3, in the crania of men we find, in order of frequency, a deep sinus and a very projecting arch, a projecting arch and a very deep sinus, lastly, a normal arch and a small sinus; 4, in the crania of women normal arches and small sinuses are much more common, next comes the deep sinuses and projecting arches, while very deep sinuses are rare and markedly projecting arches are not seen. The differences between the percentages of the sexes are rather accentuated, hence this should be borne in mind in the comparative study of skulls of the normal, the delinquent and the insane.[2]

A Fortune Given to Charities.—Mrs. Mary B. Turner, widow of Royal W. Turner of Dedham, Mass., recently devised in her will among others the following public bequests: Home for Aged Men, Boston, $2,000; Home for Aged Women, Boston, $2,000; New England Hospital for Women and Children, Boston, $5,000; Massachusetts Charitable Eye and Ear Infirmary, Boston, $2,000; Massachusetts General Hospital, Boston, to be used in providing free beds, $5,000; the Bethesda Society, Boston, $2,000. All the residue of her estate, after paying these and certain private bequests, goes in equal shares to the Massachusetts General Hospital, the Home for Aged Couples, the Home for Aged Men, the Home for Aged Women, and the Kindergarten for the Blind. The testatrix provides that if any legatee makes a contest of any of the provisions of the will, he shall forfeit his bequest.

1 Rev. Int. Med. et Chir. Prat., No. 9. 1895.
2 Rev. Int. de Med. et Chir. Prat., No. 9, 1895.

Rare Eruption Caused by Antipyrin.—A man of 30, with slight glycosuria and albuminuria and a small degree of psoriasis, after ingestion of a gram of antipyrin, had an eruption appear. This began almost immediately (in about five minutes) after administering the drug. The patient was seized with pricking sensations at first, then pruritus with flushed face, elevated pulse and appearance of red spots on the neck and then on the back. The next day the eruption consisted of about one hundred bright red spots, disseminated without order, averaging in size that of a half dollar, slightly elevated and when seized between the fingers giving the impression of rather deep inflammation of the dermis. Their evolution was rapid, and in a fortnight all had disappeared save for some plaques presenting an epidermic softening in the center (aborted bullæ) which lasted some time longer. It is interesting to note that this patient had had exactly the same series of phenomena some years before, resulting from ingestion of quinin.[1]

Relations between Delirium and Intelligence.—Eirondon maintains that the deliriant power of the insane is in direct relation to their intellectual capacity. In order to have delirium with great and numerous ideas they must have a sufficiently well-organized substratum of intellect. The lesser varieties of intellects have delusions and delirious manifestations of an elementary and uncomplicated character, formed from a few ideas and always expressed in the same monotonous fashion. On the contrary, the power of the superior psychical activity in certain intelligent insane enables them to bring calumnious accusations attested by a multitude of circumstantial details, the apparent correctness of which may lead to an error of justice. The diminution of psychical activity causes a closer union between the idea and the act, and a tendency to react from delirious conceptions by violent impulsive acts. In all cases it will be possible and useful for the alienist to seek for the intellectual substratum of the delirious person in order to better appreciate the dangers and the possibility of cure.[2]

Anaglyphs.—The London *Lancet* states that several remarkable pictures, to which the above name has been attached, have been submitted to its editor, and are commented upon by him as indicating a new departure in the physiology of illustration. The word "anaglyph" is not a new one, but it is new to the subject to which it is now applied:

"They are printed in two colors, red and blue, the two images of the same object overlapping each other laterally to about three-sixteenths or one-quarter of an inch, and vertically either to about one-sixteenth of an inch, or scarcely perceptibly. The pictures are looked at through a binocular eyeglass, one of the glasses being red, the other of a peculiar deep violet blue or blue purple. The overlapping of the images gives to the pictures when examined with the naked eye, a confused, blotchy appearance; but when looked at through the glasses the blotchiness disappears, and instead, with a clear outline, the most perfect stereoscopic effect is produced. The reason of this appears to be that the prevailing tone of the pictures is red, while the chief outlines are strongly defined in white. These are seen through the red glass. The blue outline is much fainter, and hence, although it ought to be seen through the blue glass, becomes imperceptible, owing to the deep tone of this glass. Only the stronger white and dark outlines can be easily seen through the blue glass. The main outlines, as well as the details, are seen essentially through the red glass, but by skillfully shading the red lines with blue an effect of distance is secured, and the stereoscopic effect is thus in part produced."

Dr. Henry M. Scudder, better known as a clergyman than as a medical man was, nevertheless, an M.D. of the New York University Medical College, the degree having been granted in 1853. The following is a moderate tribute to his worth found in the *Independent:*

"The life of Dr. Henry Martin Scudder has been well

1 Rev. Int. de Med. et Chir. Prat. No. 9, 1895.
2 These de Lyon, 1895.

rounded out. He was the son of one of the first American missionaries to India and served in the Arcot Mission with his father and brothers, both as medical missionary and as preacher; and when his health failed came to the United States in 1864. He immediately became one of the most prominent preachers in San Francisco, whence he was called to Brooklyn and afterward to Chicago. He was one of those ministers that are admired and loved, a man of great originality, liberality and force. He was an example of what missionaries' sons are. Dying at the age of 73, he has left his own sons, ministers and missionaries of the third generation, the best known being Dr. John L. Scudder, of the Jersey City Tabernacle. After retiring from his Chicago pulpit his heart went out again to the foreign mission work, and he spent several years in Japan with his children, who were missionaries there. It was Dr. Scudder's wish that his body should be cremated. He was not at all afraid that it would interfere with his resurrection on the last day; and as a physician he earnestly believed that it was the right thing to be done. Not a great while ago the body of one of his children was cremated. His children are as enthusiastic as he was on the subject of cremation, and will see to it that his wishes are fulfilled."

Pathogeny and Symptomatology of Movable Kidney.—Legry notes that within the past few years the ideas about the pathogeny of movable kidney have been much modified. The kidney by its anatomic position is evidently exposed to displacements, but these in turn depend on a general morbid state—a particular diathesis. This affection is more frequent in women and on the right side, and between the ages of 20 and 40. Among the determining causes pregnancy, menstrual disorders and lesions of the genital organs have been mentioned. In the author's opinion these causes are not worthy of the importance which has been assigned to them. Other causes are traumatism, alterations in the kidney, pressure from neighboring tumors and the influence of wasting diseases—tuberculosis, typhoid fever—on the fat capsule. The question of pathogeny is still unsolved, and too much importance must not be attached to Elenard's theory of enteroptosis or a general syndrome, of which nephroptosis is only an isolated symptom. In a certain number of cases movable kidney does not give rise to any functional trouble; most often, however, we notice symptoms of variable intensity which may be either abrupt or insidious in their onset. These are pain, more or less violent, which may produce a group of symptoms called renal strangulation; digestive disorders; nervous disorders which may vary in degree from simple erethism to hysteria and neurasthenia. The physical signs are the only positive ones, and palpation is the true means of diagnosis. Bimanual palpation, aided by ballottement, has been well studied and defined by Guyon. Elenard has introduced the method called nephroleptic, in which the left hand only is used. Lindner and Israel examine the patient in the lateral decubitus. Except renal strangulation, complications are rare. Nephroptosis is more of an infirmity than a malady, usually amenable, according to Legry, to a bandage and calmatives, and only exceptionally requiring surgical intervention.[1]

Treatment of Chlorosis.—Professor Hayem announces that the treatment of chlorotics is comprised under three heads—absolute rest, appropriate diet and the use of iron. Rest in bed, when sufficiently prolonged, is of the greatest importance, checking the too rapid destruction of the red globules. The choice of food is made subordinate on account of the dyspepsia which generally accompanies chlorosis. There is often a hyperpepsia of medium degree and some dilatation. In such cases the food at first should consist of milk and raw meat; later on, Hayem recommends underdone eggs, the easily digested varieties of fish, purées of green vegetables and fruit in the form of compôte. No bread is allowed for four or five weeks. In about 20 per cent. of the cases the gastropathic state is more pronounced and needs more care. Sometimes there is intense parenchymatous gastritis, with marked dilatation; again, there may be a gastritis which has caused diminished glandular secretion and a hypopeptic state. In the former case, in addition to restricted diet, massage is to be used, and lavage also, when abnormal fermentation exists. By the use of these measures it is generally possible to begin ferruginous treatment in from two to four weeks. In hypopeptic conditions, however, iron may be used from the first, giving it before meals and hydrochloric acid a half hour after eating. As to the best salt of iron to exhibit, Hayem has been convinced for a long time that it is the protoxalate. Under its use we can see the patients regain their color and the duration of treatment is reduced to the minimum, which is very important in those with stomach complications, which often persist after the chlorosis has been cured.[1]

[1] Jour. de Med. et Chir. Prat. No. 9, 1895.

Washington Notes.

Medical Society of the District.—The medical society has adjourned to meet on the first Monday in July, the semi-annual meeting for the election of members and transaction of special business.

The Washington Obstetrical and Gynecological Society.—The two hundred and thirty-first meeting of the society was held on the 21st inst., at which the discussion of Dr. Scott's paper of the last meeting was continued with renewed interest. Dr. Edmund L. Tompkins reported an interesting case of "Criminal Abortion" with retained secundines, in which the abortionist had made a large rent in the posterior surface of the organ at the utero-vaginal junction. The membranes were removed and the uterus curetted through the rent by Dr. H. L. E. Johnson, in consultation. Dr. Carr opened the discussion and was followed by many other members. Dr. Nash presented a specimen recently removed by Dr. H. L. E. Johnson of "Fibroma of Uterus" with four tumors attached, which were supposed to be sarcoma with a fibroid of right ovary. The fibroma contained a large pus cavity. There was an atresia and entire obliteration of the infra-vaginal portion of the cervix. An interesting discussion followed and on motion was continued to the next meeting to learn the microscopic report on the specimens. At the next meeting the members will have the pleasure of listening to the Annual Address of the President.

Health of the District.—The report of the Health Officer for the week ended June 15, is as follows: number of deaths: white, 42; colored, 37; total, 79. Death rate per 1,000 per annum, white, 11.90; colored, 22.11; total 15.55. Death rate per 1,000 per annum for corresponding week last year, 27.15. Stillbirths, white, 4; colored 4; total, 8.

Medical Department of Columbian University.—The faculty of the Columbian Medical School has elected Dr. Walter Reed, U. S. A. Curator Army Medical Museum and Professor of Clinical and Sanitary Microscopy in the Army Medical School, Professor of Pathology and Bacteriology. Dr. M. T. Phillips, Chief of the Division of Climatology in the U. S. Weather Bureau has been elected Professor of Hygiene. The corps of demonstrators has been enlarged, and $600 appropriated for the purchase of additional instruments.

Louisville Notes.

Commencements.—The annual Commencement of Louisville's two spring and summer schools took place during the past week. The Kentucky School of Medicine June 20, and the Medical Department of Central University of Kentucky June 18. There were thirty graduates in the medical department of the Hospital College, and eighteen from the

[1] Rev. Int. de Med. et Chir. Prat., No. 9, 1895.

dental department. Addresses were made by the Dean, Dr. P. R. Taylor, the President, Dr. J. A. Larrabee, and the Doctorate address by Dr. L. S. McMurtry. There were twenty-three awards of prizes.

KENTUCKY SCHOOL OF MEDICINE.—At the Commencement exercises of this school thirty-three graduates received their diplomas, the degrees being conferred by the President of the Board of Trustees, Mr. James Helen. The valedictory address was delivered by Dr. H. Lon Carter, in which he made feeling reference to the sad deaths of a fellow student, Mr. W. W. Culpepper; the honored President of the Board of Trustees, Dr. John A. Broddus and Dr. W. Carroll Chapman, a member of the Adjunct Faculty of the College. The Dean, Dr. W. H. Wathen, referred to the added requirements of the Kentucky School, the present class being the first to graduate under the three-year rule; the next class being required to have attended four regular graded courses of lectures of six months each. Eight prizes and medals were awarded.

ALUMNI ASSOCIATION.—The annual meeting of the Alumni Association of the Kentucky School of Medicine, was held in the college building. The following were elected officers for the ensuing year: President, Prof. Henry Orendorf; Vice-Presidents, Dr. Henry E. Tuley, Dr. Wm. V. Laws; Secretary-Treasurer, Dr. Louis Frank. Vice-Presidents from every State having more than ten graduates were then elected. The graduating class were enrolled as members. The Association voted to offer a medal to the first honor man in the second year class, and it was suggested that a member of the alumni deliver the address each year at the Commencement, and that an annual banquet be given the graduating class.

WISHARD.—Dr. F. M. Wishard, of Indianapolis, President of the Mississippi Valley Medical Association has been in the city, the guest of Dr. Thos. Hunt Stucky. He was entertained at the Kenton Club one evening during his visit by Dr. Stucky.

MITCHELL DISTRICT MEDICAL SOCIETY.—The following papers have been promised by Louisville physicians at the meeting of this society July 5 and 6, at West Baden, Ind.: Some Wretched Pelvic Cases, by Ap. Morgan Cartledge; Litholapaxy, by Samuel Cochran; Report of Cases, by M. F. Coomes; The Treatment of Corneal Ulcers, by S. G. Dabney; The Ocular Symptoms of Kidney Disease, by T. C. Evans; A Contribution to the Study of Septic Peritonitis, by Louis Frank; Advances in Infantile Therapeutics, by J. A. Larrabee; What Operations in Rectal Surgery are Unjustifiable? by Jos. M. Mathews; The Use and Abuse of the Curette in Gynecologic Practice, by L. S. McMurtry; Headaches, by Curran Pope; Intestinal Obstruction, with Cases, by Fouchee Samuel; Some Recent Experiences with Gold as a Therapeutic Agent, by Thos. H. Stucky; When to Enucleate in Traumatic Cyclitis, by P. R. Taylor; Vaginal Hysterectomy versus Laparotomy for Pelvic Suppuration, by Wm. H Wathen.

WESTERN INSANE ASYLUM.—Dr. B. W. Stone, Superintendent of this institution, located at Hopkinsville, recommends an addition to the asylum, especially the female department. The proposed additions would cost $13,500, and Dr. Stone states that part of the $350,000 which must be paid into the State treasury as a result of the bank tax decision, should be devoted to asylum improvements.

DENTISTS.—The twenty-fifth annual meeting of the Kentucky State Dental Association was held in Lexington during the past week under the Presidency of Dr. Howard Van Antwerp, of Mt. Sterling.

NEWSPAPER ASEPSIS.—The following clipping from an evening newspaper speaks for itself: "The condition of —— continues critical. Dr. ——, who attended him used a new case of instruments in removing the bullet, and has taken every precaution against blood poisoning."

DEATH REPORT.—The Health Officer's mortality report for the week shows a total of 52 deaths and 2 stillbirths. Of these consumption caused 15, organic heart disease 5; 28 were male, 24 female; 33 white, 19 colored.

ACADEMY OF MEDICINE.—This society has adjourned until the first Monday in September.

WATHEN.—At the golden jubilee of the University of Notre Dame, last week, before the many distinguished guests present, a public announcement was made that the University had conferred the degree of LL.D. upon William H. Wathen, A.M., M.D., in recognition of his worth as a scholar, teacher and doctor.

THE PUBLIC SERVICES.

Army Changes. Official list of changes in the stations and duties of officers serving in the Medical Department, U. S. Army, from June 15, 1895, to June 21, 1895.

Capt. MARLBOROUGH C. WYETH, Asst. Surgeon, is granted leave of absence for two months, to take effect the latter part of August, 1895.

Capt. GEORGE MCCREERY. Asst. Surgeon, will be relieved from duty at Ft. D. A. Russell, Wyo., and will report in person to the commanding officer, Ft. Niobrara, Neb., for duty at that post.

Capt. CHARLES RICHARD, Asst. Surgeon, is granted leave of absence for three months, to take effect when he shall be relieved from his present duties, on or about June 30, 1895.

First Lieut. WILLIAM F. LEWIS, Asst. Surgeon, is granted leave of absence for two months and twenty-three days, to take effect on or about July 6, 1895.

Capt. JAMES E. PILCHER, Asst. Surgeon, leave of absence granted on surgeon's certificate of disability, is extended four months, on surgeon's certificate of disability, and permission is given him to go beyond sea.

Navy Changes. Changes in the Medical Corps of the U. S. Navy for the week ending June 22, 1895.

Medical Director A. A. HOEHLING, placed on retired list.

Medical Inspector G. W. WOODS, ordered for examination preliminary to promotion to Medical Director.

Surgeons G. F. WINSLOW and R. A. MARMION, ordered for examination preliminary to promotion to Medical Inspector.

Marine-Hospital Changes. Official list of changes of stations and duties of medical officers of the U. S. Marine-Hospital Service, for the fifteen days ended June 15, 1895.

Surgeon GEORGE PURVIANCE, relieved from duty at Philadelphia, Pa., (temporarily), and detailed for duty on board relating to Ford's Theater disaster, June 8, 1895.

Surgeon W. A. WHEELER, detailed as chairman of board for physical examination of candidate, revenue cutter service, June 1, 1895.

P. A. Surgeon S. D. BROOKS, granted leave of absence for twenty days, June 14, 1895.

P. A. Surgeon J. H. WHITE, detailed as recorder of board for physical examination of candidate, revenue cutter service, June 1, 1895.

P. A. Surgeon W. J. PETTUS, granted leave of absence for thirty days, June 6, 1895.

Asst. Surgeon L. E. COFER, to inspect unserviceable property at San Diego Quarantine Station, June 12, 1895.

Asst. Surgeon H. S. CUMMING, relieved from temporary duty at Boston, Mass., and ordered to rejoin his station at New York, N. Y., June 3, 1895.

LETTERS RECEIVED.

Antikamnia Chemical Co., St. Louis, Mo.; Arnold, H. A., Ardmore Pa.; Atkinson, W. B., Philadelphia, Pa.

Battle & Co., St. Louis. Mo.; Ball-Bearing Co., Boston, Mass.; Bowker, E. M., Boston, Mass.; Busey, S. C., Washington, D. C.

Christopher, H., St. Joseph, Mo.: Craig, Alex. R., Columbia, Pa.

Day, L. T., Westport, Conn.; Dellenbaugh, C. C., Portland. Mich.

Edwards, J. B., Maustin, Wis.; Ely, J. S., Barnesville, Ohio.; Globe Mnfg. Co., Battle Creek, Mich.

Harriman, J. W., Iowa City, Iowa; Hawkins, G. E., Chicago, Ill.; Hartley, Henry, Vicksburg, Miss.; Harman, G. G., Huntingdon, Pa.; Hummel, A. L., Philadelphia, Pa. (3).

Irwin, Fairfax, Washington, D. C.

James, T. A., Ashley, Pa.; Johnson, J. P., Galveston, Texas; Johnson, W. W., Advertising Co., Chicago, Ill.

Kansas City Advertising Co., Kansas City, Mo.; Kuhlman, C. G., San Francisco, Cal.

Lambert Pharmacal Co., St. Louis, Mo.; Laplace, E., Philadelphia, Pa.; Lamb, Thos., Highlands, N. C.; Lehn & Fink, New York, N. Y.; Lord & Thomas, Chicago, Ill.

Marshall, Geo. M., Columbus, Ohio; Mowery, H. A., Marietta, Pa.

Newman, H. P., Chicago, Ill.

Parmele, Chas. Roome, New York, N. Y.; Patterson, M. F. Des Moines, Iowa.

Raymond, H. I., Fort Washakie, Wyo.; Renz & Henry Pharmacal Co., Louisville, Ky.; Rhodes, J. E., Chicago, Ill.; Russell. E. David, Cedar Bluffs, Iowa; Rudy, Martin. Lancaster, Pa.

Savage, G. C. Nashville. Tenn.; Saunders, W. B., Philadelphia, Pa.; Sargent, E. H., Chicago. Ill.; Scribner's, Chas., Sons, New York, N. Y.; Smart, Chas., Washington, D. C.; Stowell. C. A., Washington, D. C.; Summers. T. O., St. Louis, Mo.; Sturtevant, B. F., Chicago, Ill.

Thilberg, John, Rockford, Ill.; Thomas, F. S., Council Bluffs, Iowa; Towler. S. S., Marienville, Pa.

Van Cleve, A. H., Eddy, N. M.

Warner, W. R. & Co., Philadelphia, Pa.; Welk, J. E., Mt. Olivet, Ky.; Wyckoff, R. M., Brookly, N. Y.